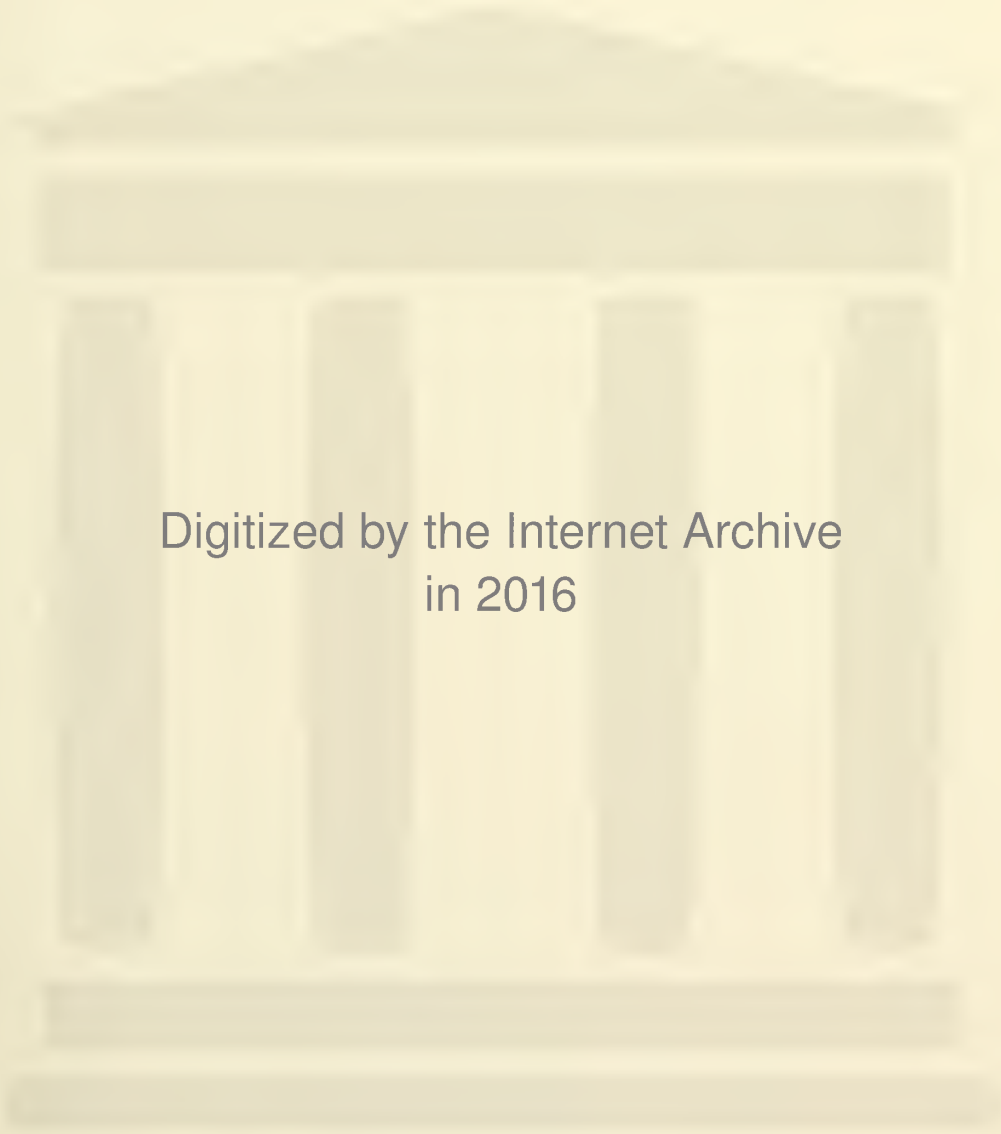
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The Journal

of the

Michigan State Medical Society

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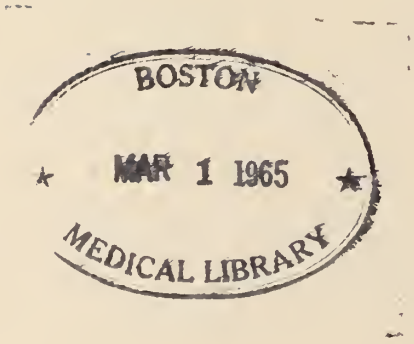
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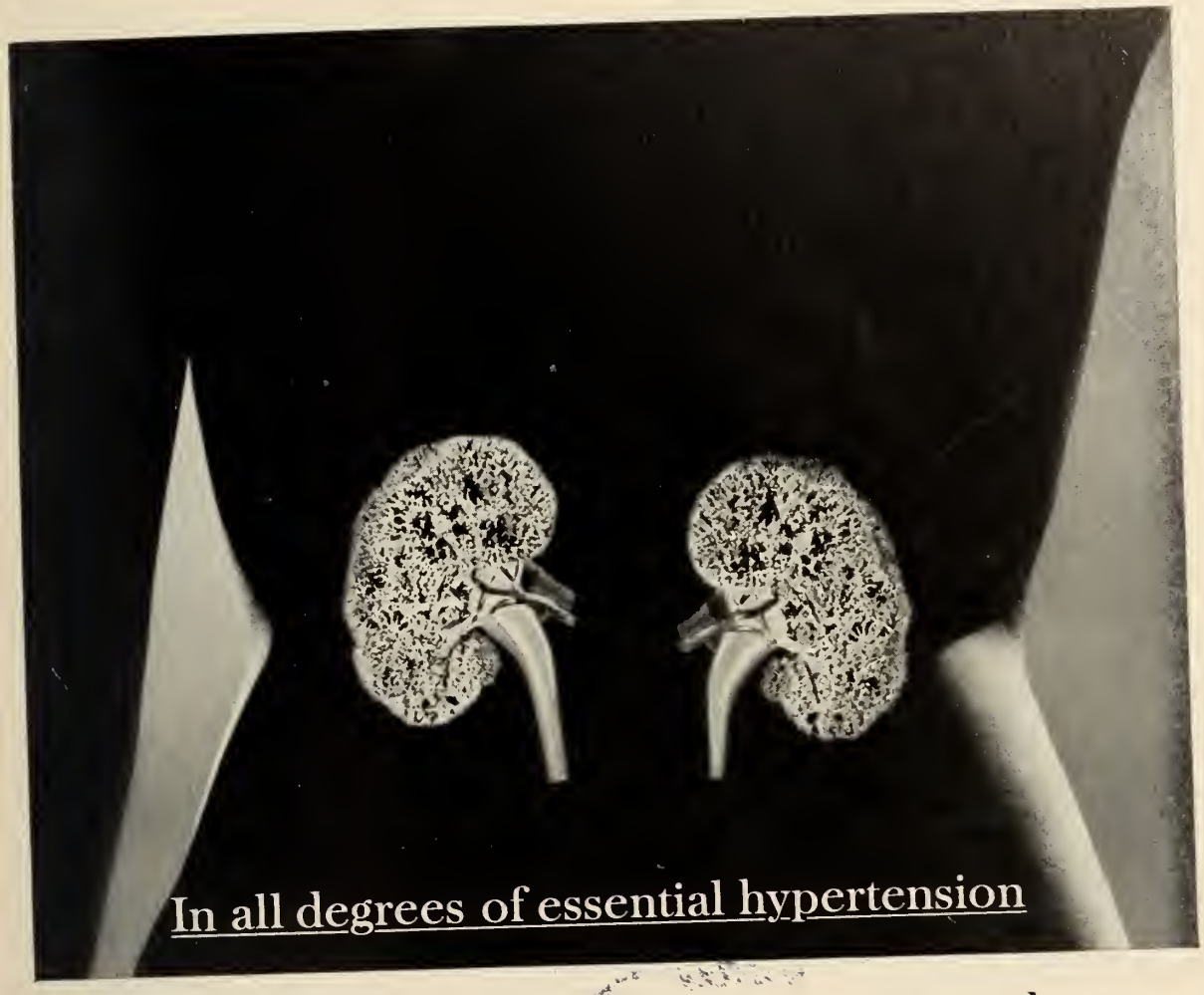
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VOLUME 63
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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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*Schwartz, I. R.:
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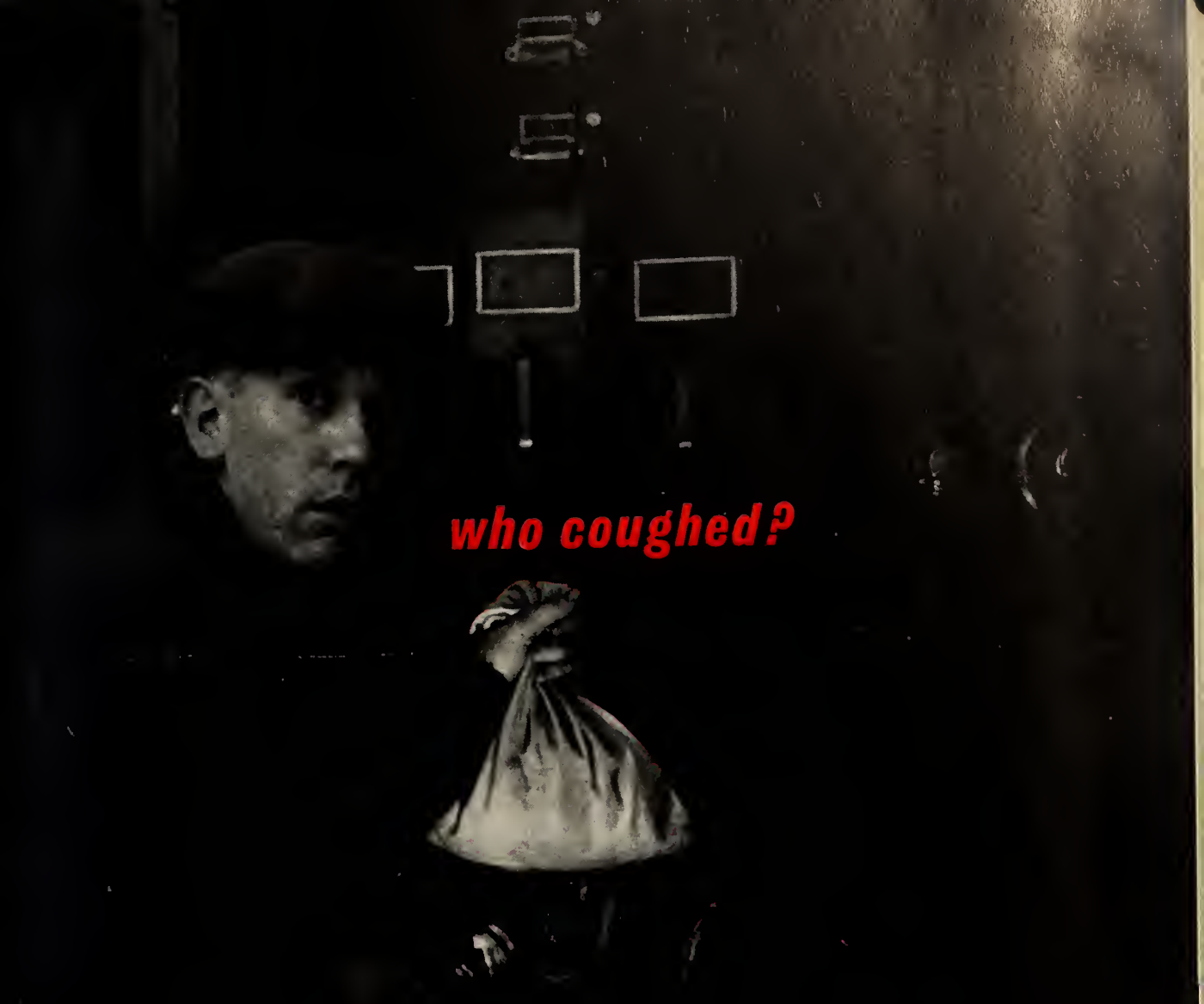
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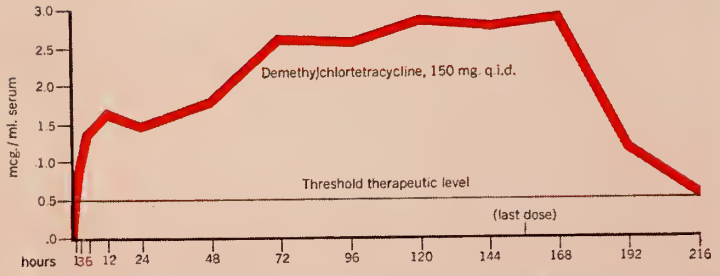
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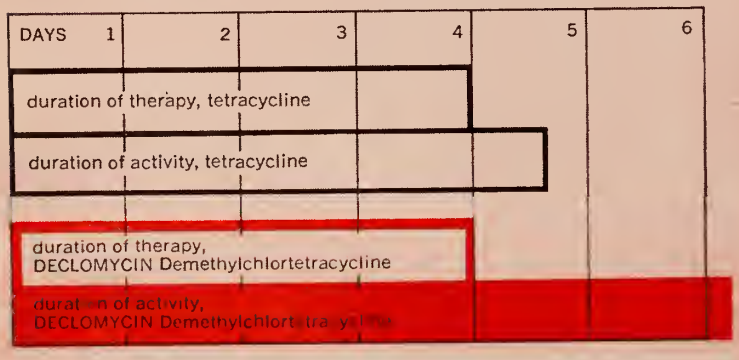


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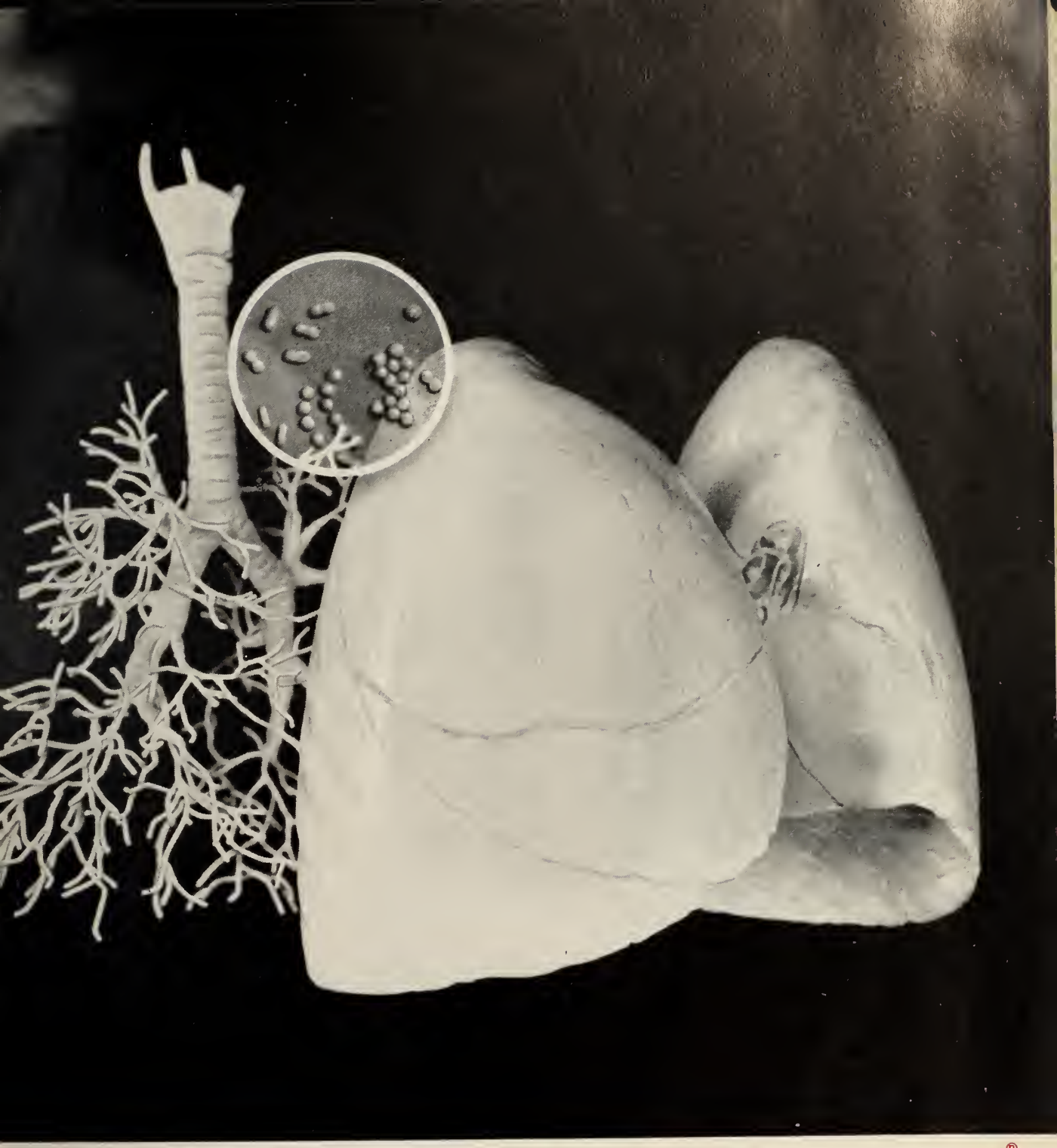
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President's Page

WRITE TO YOUR CONGRESSMAN TODAY



Arlen J. Johnson M. D.

President
Michigan State Medical Society

The 1964 election campaign is on! Presently, our attention is focused on Washington, D. C., and the Congress.

Chairman Wilbur Mills of the House Ways and Means Committee has announced the resumption of public hearings on the King-Anderson Bill for January 20 or 27. Major presentations in favor of the bill will be made by the AFL-CIO and others.

Proponents of the bill are expected to launch a supreme election year effort to secure its passage in 1964.

Edward R. Annis, M.D., President of the American Medical Association, warned in his year-end Call to Arms message:

* * *

"We can expect the proponents of federalized medicine financed through increased payroll taxes to resort to every means at their command to force the measure out of the Ways and Means Committee.

"Unless Congress knows what the voters back home think about this issue, they will be exposed only to the pressure being applied to win approval.

"We must counter their drive with our greatest effort to mobilize public opinion against this ill-conceived, unjustified legislation."

* * *

The Michigan State Medical Society accepts this challenge of President Annis for concerted action.

Our all-out campaign is now underway. All men of medicine are being asked to participate. Each county medical society should take immediate steps to activate all phases of its "Operation Hometown" campaign.

To assist in "Operation Hometown" it would be extremely effective if every MD would be responsible for sending 10 letters to his congressman.

It's our right and duty to let our representative in the Congress know our attitude and that of our patients on the King-Anderson proposal. If your congressman is known to oppose medicare—back up his stand with letters to strongly approve his position. If your congressman is known to be in favor of King-Anderson—extend even greater effort to convince him that his constituents do not favor his position. He may not change his position but letters in quantity could change his emphasis on the issue.

Lastly, to extend a full measure of effort, may I urge each doctor to join MD PAC-AMPAC. Both the state and the national political action committees have the endorsement of the Michigan State Medical Society. Your membership in this organization can effectively back medicine's fight to remain free.

Michigan Clinical Institute To Feature Panel Discussions March 11-13 In Detroit



The 1964 MCI will follow the program format which proved so successful at the 1963 Annual Session in Grand Rapids. Panel discussions will cover a subject in depth with several physician-teachers expressing their points of view and relating experiences. Joseph L. Posch, M.D., Detroit, is Chairman of the Program Committee.

The daily clinical television program, in color, will be telecast over a closed circuit from Detroit's Receiving Hospital by Smith Kline and French Laboratories. Donald H. Kaump, M.D., is Chairman of the Television Program Committee.

The Michigan Clinical Institute will be held in the Sheraton-Cadillac Hotel, Detroit, beginning Wednesday, March 11, and closing at Noon, March 13.

Kenneth H. Johnson, M.D., Lansing, Chairman of the MCI Committee on Arrangements, said that Clinical Roundtables would be continued as an MCI plus feature.

Following are subjects of presentations for each day:

WEDNESDAY, MARCH 11

A.M.

8:00 Clinical Roundtables
"Hernia"
"Complications of Gall Bladder Surgery"
"Trauma in Orthopedics"

9:00 General Assembly
"Renal Vascular Hypertension"

10:30 Clinical Television
"Peptic Ulcer"
"Maxillo-Facial Trauma"

P.M.

1:30 General Assembly
"Chest Trauma"
"Cardiac Surgery in Children"

8:00 Evening Symposium
"Problems in the Sexual Education of Children"
"Common Sexual Problems in Marriage"
"Some Techniques for Counselling on Sexual Difficulties"

THURSDAY, MARCH 12

A.M.

8:00 Clinical Roundtables
"Use of Anti-Coagulants in Heart Disease"
"Mental Attitudes Toward Heart Disease"
"Use of Extraordinary Measures to Maintain Life"

9:00 General Assembly
Cardiovascular Lectures

10:30 Clinical Television
"Pulmonary Function Through the Ages"
"Renal Failure"

THURSDAY, MARCH 12

P.M.

1:30 Internal Medicine Lectures
Michigan Foundation Lecture—"Moral Decisions Facing Medicine Arising from Scientific Advances"
Michigan Cancer Coordinating Committee Lecture

8:00 Evening Symposium
"When Our Parents Get Old"

FRIDAY, MARCH 13

A.M.

8:00 Clinical Roundtables
"Infectious Diseases in Children"
"Anesthesia in Obstetrics"
"Genetics and Chromosomes"

9:00 General Assembly
"Obstetrics and Gynecology"

9:30 "Pre- and Latent Diabetes in Pregnancy"

10:30 Clinical Television
"A Problem in Gynecology"
"Neurological Problems in Childhood"

John Pardee in Chicago

John K. Pardee, formerly a member of the MSMS staff, is now acting secretary-treasurer of the Paper Industry Management Association in Chicago. "Jack" left MSMS several years ago after serving as public relations field secretary at the Wayne County office to join the New York State Medical Society. He was director of the NYSMS business division and executive director of the recently-formed New York State Association of the Professions until accepting the Chicago position.

Michigan Medical Meetings

Congress of the Professions, February 7-8, Jack Tar Hotel, Lansing.

Third Annual Canadian-American Medical and Dental Ski Association, February 17-19, Harbor Highland, Harbor Springs.

Genesee County Medical Society "Alcoholism Day," February 19, Hurley Hospital, Flint.

Third Annual Thyroid Workshop, February 22, Woman's Hospital, Detroit.

Michigan Heart Association "Heart Day," February 22, Statler-Hilton, Detroit.

MSMS County Secretaries PR Seminar, February 27, Jack Tar Hotel, Lansing.

Michigan Clinical Institute, Sheraton-Cadillac, March 11-13, Detroit.

Michigan State Medical Assistants Education Seminar, March 11, Statler-Hilton, Detroit.

Michigan State Nurses Association Operating Room Nurses Institute, Statler-Hilton, Detroit, March 12-13.

MSMS Maternal and Perinatal Mortality Workshop, May 14-15, Gull Lake Conference Center, Battle Creek.

Wayne State University Clinic Day and Alumni Reunion, May 20, Detroit.

Form MSMS Committee On Medicine-Religion

The new MSMS Committee on Medicine and Religion held its organization meeting at the MSMS headquarters in December. R. L. Rapport, M.D., Flint, has been appointed to serve as chairman.

The MSMS Committee is one of 36 state committees being formed, at the suggestion of the AMA Department of Medicine and Religion.

The director of the AMA department is Paul B. McCleave, LL.D., who declares: "There is a sincere interest on the part of physicians to seek ways and means of communicating with the clergy about the total care and treatment of patients. This interest and concern on the part of medicine has made possible the very fine reception of an organizational plan whereby county medical societies conduct programs involving clergy in discussions about the relationship of medicine and religion."

A 16 mm color and sound film "The One Who Heals," has been produced for public viewing and for the county medical societies in their discussions with the clergy. Until March, 1964, the film will be used by county medical societies and for televised programs. After that time, it will be available for church groups, service clubs, schools, Parent-Teacher Associations and other organizations.

Members of the MSMS committee with Chairman Rapport are W. C. Beets, M.D., Grand Rapids; R. R. Cooper, M.D., Grosse Pointe; R. A. Frary, M.D., Monroe; A. E. Heustis, M.D., Lansing; D. V. Sargent, M.D., Saginaw; R. W. Teed, M.D., Ann Arbor; J. R. Dehlin, M.D., Gladstone.

MSMS Section Officers Meet On '64 Annual Session Plans

Plans for the 1964 Annual Session were advanced at a December meeting of MSMS section officers and the Annual Session Program Committee, Harry A. Towsley, M.D., Chairman.

The Annual Session will be held on September 20-25, 1964, at the Sheraton-Cadillac Hotel, Detroit.

The officers and committee members confirmed overall arrangements of the 1964 Annual Session and discussed improvements in the coordination and scheduling of section meetings.

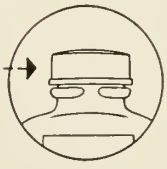
Because the all-panel program of the 1963 Annual Session was so highly commended by audiences, the new format will be used again at the 1964 Annual Session in Detroit.

HOW TO WIN FRIENDS...

little



New
Orange Flavored
Bayer Aspirin for Children
is sweet
all the way through,
so children
take it readily.
The GRIP-TIGHT CAP ----------
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helps keep them
from taking it
on their own.



Bottles of 50 tablets
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Geigy
brand of
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Tablets of 100 mg.
Proved by over a
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experience
It works!
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Geigy Chemical
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Wayne Begins Series On Ethics, Jurisprudence



A new service for the members and medical students has been inaugurated by the Wayne County Medical Society. The first in a series of "Courses in Medical Ethics and Medical Jurisprudence" was held at the Wayne Society building on December 6.

The idea for the courses was developed by a subcommittee of the WCMS Medical Education Committee. Ralph Cooper, M.D., is chairman of the subcommittee and Robert Whitrock, M.D., is chairman of the parent committee.

The series is for junior and senior medical students, interns and residents and new county society members.

Laurence Segar, M.D., immediate past-chairman of the WCMS Ethics Committee, taught the first session about "Basic Principles of Medical Ethics." Each course will be conducted the first Friday of each month from 5:30 to 6:30 p.m.

Other subjects and speakers include the following:

January 3—"Basic Concepts of Medical Jurisprudence," Frederick Buesser, WCMS Legal Advisor

February 7—"Ethical Responsibilities of the Physician to his Medical Society," Victor Nelson, M.D., chairman of Ethics Committee

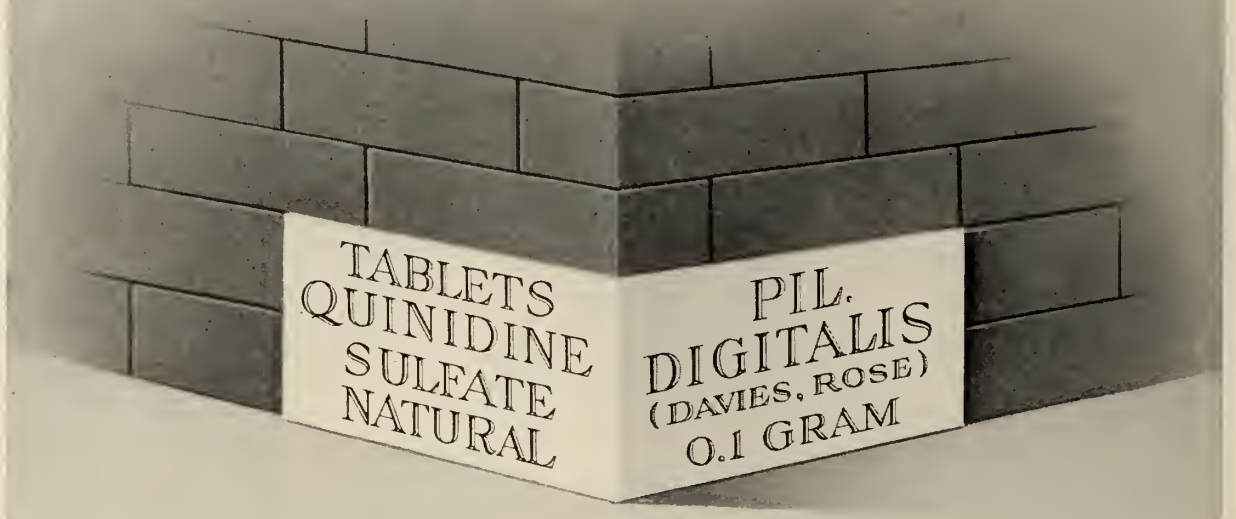
March 6—"Medical Malpractice," J. P. Schureman, Attorney, Medical Protective Co.

April 3—"Ethical Responsibilities of the Physician to his Patients," A. H. Hirschfeld, M.D., member and psychiatric consultant to Ethics Committee

May 1—"Workmen's Compensation Cases," Malcolm Denise, Attorney, Ford Motor Company, and member of Board of Michigan Medical Service

June 5—"Ethical Responsibilities of the Physician to Other Physicians," Donald Sweeny, Jr., M.D., editor and past member of Ethics Committee

A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

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In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

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carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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release for hostility?

Overeating is often an outlet for feelings of hostility. Many people take out their anger by overindulgence at or between meals. As a result they become overweight.

'Eskatrol' *Spansule* capsules both control appetite and relieve the emotional stress that causes overeating. That's why so many patients are losing more pounds with 'Eskatrol'.

ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules

because emotions play an important role in overweight

Brief Summary of Principal Side Effects and Cautions

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory. *Cautions:* 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

For complete prescribing information, please see *PDR* or available literature.

Supplied: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F

Legislators Grateful For Aid Station

The "sincere appreciation" of the Michigan Legislature has been officially expressed to the Michigan State Medical Society and the Ingham County Medical Society for the medical first aid station being operated at the Capitol Building for the legislators.

Following is the official resolution adopted by both the Senate and the House of Representatives:

STATE OF MICHIGAN

Michigan Legislature

House Concurrent Resolution No. 23

Offered by Representatives Edwin A. FitzPatrick, John J. Fitzpatrick, Little, Murphy, Strange and Rockwell

A concurrent resolution of appreciation to the Michigan State Medical Society and the Ingham County Medical Society.

WHEREAS, The Michigan State Medical Society and the Ingham County Medical Society has erected, equipped and are maintaining a First Aid Station for the convenience of the members of the Michigan Legislature; and

WHEREAS, This First Aid Station, located on the fourth floor of the State Capitol Building, has the services of a registered nurse who is on duty whenever the Legislature is in session for the convenience of the members of the Legislature; and

WHEREAS, As the demands placed on the legislators are very heavy at times, it is extremely beneficial to have such a First Aid Station and competent medical personnel available for the health and welfare of the Legislature; now therefore be it

RESOLVED BY THE HOUSE OF REPRESENTATIVES (the Senate concurring), That the members of the Legislature take this opportunity to express their sincere appreciation to the Michigan State Medical Society and the Ingham County Medical Society for their thoughts and consideration in the placing, maintaining and staffing of the medical First Aid Station for the convenience of the Michigan Legislators; and be it further

RESOLVED, That a copy of this resolution be transmitted to the Michigan State Medical Society and the Ingham County Medical Society.

Adopted by the House November 14, 1963.

Adopted by the Senate November 14, 1963.

BERYL I. KENYON
Secretary of the Senate

NORMAN E. PHILLEO
Clerk of the House of Representatives



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®
meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

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MSMS Reaches Teachers At Mecosta-Osceola Institute

More than 300 teachers from Mecosta and Osceola counties gained new insights into school health matters at a two-county Teachers' Institute, held in December in Reed City.

MSMS was one of the state health agencies which presented an exhibit, provided materials and helped to answer questions. The AMA exhibit "Health Appraisal of the School Child" was lauded as one of the best.

The event was co-sponsored by the Michigan School Health Association and the Michigan Education Association.

Doctors who participated on the program were E. J. Brenner, M.D., Mt. Pleasant, and Harold J. Lambert, M.D., Lansing.

Rumor Rides Home

It is difficult for the medical profession as a whole to have good public relations among people who feel resentful toward one or two doctors. There is an old saying that good news travels fast. Don't you believe it. Bad news spreads like wildfire, and rumor rides home while the truth is asking directions.

—Jim Reed of AMA to
Pennsylvania Medical Society

AMA Meeting on Film

"Medifilm Report V," a 32-minute filmed report of highlights of the American Medical Association's 112th Annual Meeting in Atlantic City, is now available to medical and allied groups by Schering Corporation.

A print may be obtained by writing to the AMA at 535 North Dearborn Street, Chicago, Ill., or to the Audio-Visual Department, Schering Corporation, Union, N. J.

Reminder Appeal

The MSMS Public Relations Committee recognizes the necessity for continuing a very active campaign to resist socialized medicine legislation and to that end is urging the county medical societies to embark upon the American Medical Association recommended campaign known as OPERATION HOMETOWN.

This will reach its highest point of effectiveness during the first six months of 1964.

—R. W. Teed, M.D., *Chairman*
MSMS Committee on Public Relations

Say you saw it in the Journal of the Michigan State Medical Society



"Upon arising, nose was open". . . or how another happy patient describes the nasal decongestant action of Dimetapp Extentabs*—how would *your* patients describe it?/In Sinusitis, Colds, U.R.I., up to 10-12 hours' clear breathing on one tablet/Also available: Dimetapp Elixir, for t.i.d. or q.i.d. dosage.

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[Dimetane® (brompheniramine maleate), 12.0 mg.; phenylpropanolamine hydrochloride, 15 mg.; phenylephrine hydrochloride, 15 mg.]

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* LINICAL REPORT ON FILE, MEDICAL DEPT., A.H. ROBINS CO., INC.

BRIEF SUMMARY: *Indications:* Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. *Side Effects:* In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. *Precautions:* Administer with caution in cardiac or peripheral vascular diseases and hypertension. *Contraindications:* Antihistamine sensitivity. Not recommended for use during pregnancy.

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For specialists in Internal Medicine; Eye, Ear, Nose, Throat; Pediatrics; Dermatology and General Practice.

Specific desensitization to restore allergic balance



You—or your nurse—can quickly and safely determine any patient's allergic imbalance . . . with a Barry Diagnostic Set costing as little as $2.50. On the basis of the patient's history and skin test reactions, a BARRY IMMUNOREX treatment will then be carefully compounded for *specific* desensitization to restore allergic balance and achieve *lasting immunity*. For technical data, write Medical Department, Barry Laboratories—for product demonstration, see your physicians supply dealer.

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LOCAL ALLERGENS FOR MICHIGAN PHYSICIANS

Facts About State's Hospitalized Aged

By Richard M. Campau

MSMS Research Director

On a day selected at random—July 11, 1963, to be exact—an independent survey of the total adult population in 182 Michigan general hospitals was conducted by the Michigan Hospital Association to determine how the bill for each patient over 65 was actually paid.

On that day there were 19,870 adults hospitalized in the 182 hospitals that replied to the survey, of which 5,295 (or 26.6 per cent) were 65 years and older. The table below gives a complete breakdown of the recorded source of payment for this age group.

MICHIGAN HOSPITAL ASSOCIATION INVENTORY OF HOSPITALIZED AGED
July 11, 1963

Total Adult Patients	19,870	(100 %)
Patients 65 and Over	5,295	(26.6%)
Number of Replies	182	

Sources of Payment for Patients 65 Years and Over

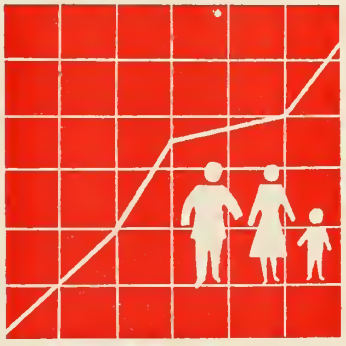
Medical Assistance for the Aged (MAA)	542	(10.2%)
Old Age Assistance (OAA)	294	(5.6%)
County Welfare	255	(4.8%)
Blue Cross	2,564	(48.4%)
Commercial Insurance	827	(15.6%)
Private Payment	706	(13.3%)
Other or Unknown	107	(2.0%)

Certainly, this survey points out that voluntary and private resources remain the major source of hospital bill payment for the aged. Blue Cross, Commercial Insurance and Private Payment paid for hospital expenses of 4,097 patients or 77.3 per cent of the total.

The fact that Medical Assistance for the Aged (MAA), Old Age Assistance (OAA), and County Welfare provided for 1,091, or 20.6 per cent of the total, indicates their effectiveness in helping those who need help.

Although this survey did not include data regarding the total hospital charges incurred by those it covered, the following information furnished by Michigan Hospital Service gives average contract charges in 1962 per admission for patients 65 and over by selected diagnostic category.

Diagnostic Category	Avg. Contract Charge Per Admission	Average Stay	Average Per Diem Charge
Circulatory System (surgical case)	$503	12.97 days	$38.78
Circulatory System (medical case)	384	12.15 days	31.60
Respiratory System (surgical case)	592	15.34 days	38.63
Respiratory System (medical case)	320	10.40 days	30.80
Genitourinary System (surgical case)	458	12.32 days	37.18
Genitourinary System (medical case)	325	10.67 days	30.44
Bones and Organs of Movement (surgical)	482	14.56 days	33.14
Bones and Organs of Movement (medical)	403	14.34 days	28.09
Accidents (surgical case)	654	20.54 days	31.82
Accidents (medical case)	332	13.11 days	25.31



SHEDD'S SAFFLOWER MARGARINE

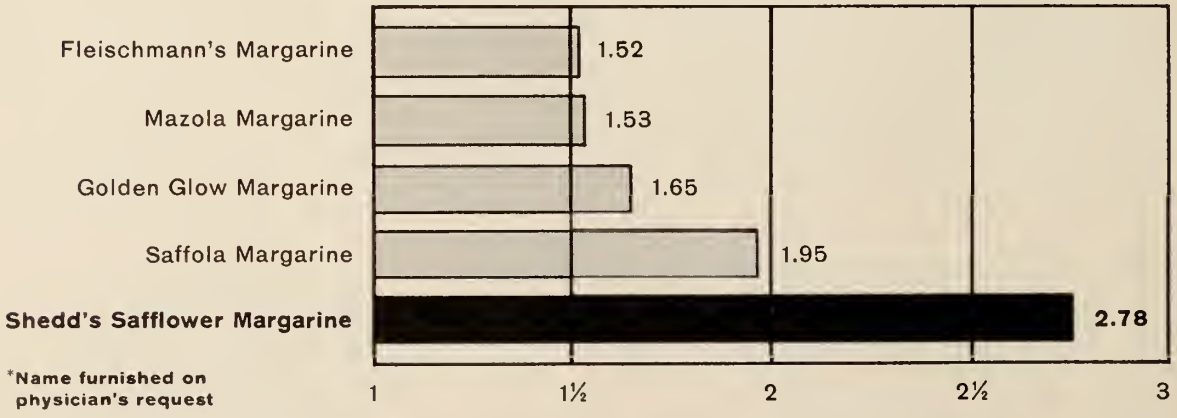


RATED BEST!!

in ratio of poly-unsaturates to saturated fats

An outstanding, independent research laboratory* was asked to compare five leading margarines for their proportions of beneficial poly-unsaturates to saturated fats. All samples were purchased at store level by shoppers for the research laboratory, and the results given are the average of two tests made on each margarine.

THE RESULTS OF THIS TEST PROVED SHEDD'S SAFFLOWER MARGARINE HAS A HIGHER RATIO OF POLY-UNSATURATES TO SATURATED FATS.

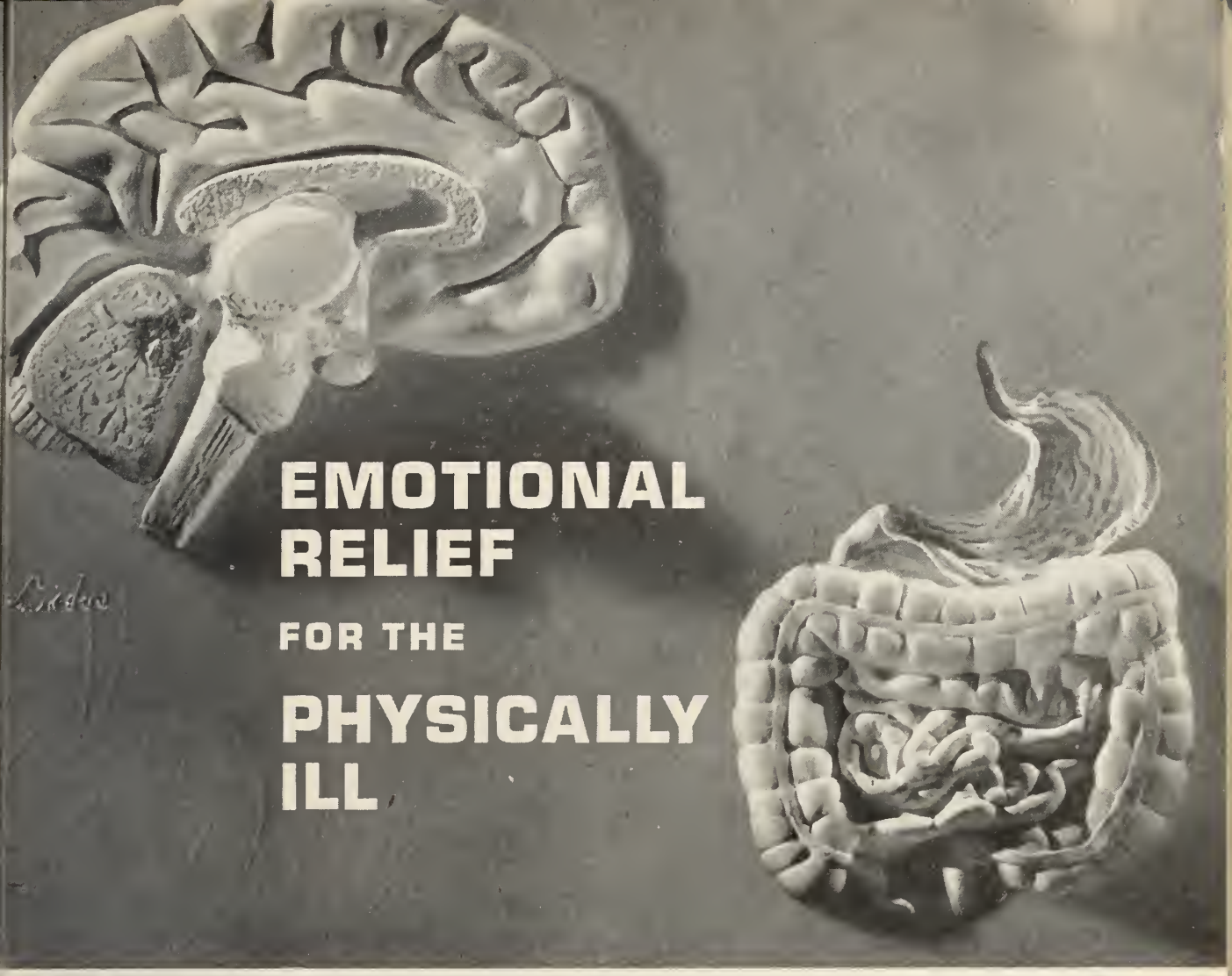


*Name furnished on physician's request

Shedd's Safflower Margarine Tastes Best, too!

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Say you saw it in the Journal of the Michigan State Medical Society



RELIEVES ANXIETY, APPREHENSION AND TENSION..



All day long

. . . keeps the patient calm, and the mind clear.



All night too

. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

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Regardless
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'Empirin'
Compound
to relieve
pain and
lower fever



Also: 'Empirin'® Compound with Codeine Phosphate*
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*Warning—may be habit forming

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Special cough formula for children

Pediacof®

Each teaspoon (5 ml.) contains codeine phosphate 5 mg., Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) 2.5 mg., chlorpheniramine maleate 0.75 mg. and potassium iodide 75 mg.

soothing decongestant and expectorant



bright red, pleasant-tasting, raspberry-flavored syrup

Pediacof is different. It is designed especially for children, and each ingredient is in the right proportion. The potassium iodide in Pediacof is so well masked that it is virtually unnoticeable. Children like the sweet raspberry flavor of bright red Pediacof.

Dosage: Children from 6 months to 1 year, ¼ teaspoon; from 1 to 3 years, ½ to 1 teaspoon; from 3 to 6 years, 1 to 2 teaspoons; and from 6 to 12 years, 2 teaspoons. These doses are to be given every four to six hours as needed.

How supplied: Bottles of 16 fl. oz.

Available on prescription only.
Exempt Narcotic.

Side effects: The only significant untoward effects that have occurred are mild anorexia and an occasional tendency to constipation. However, discontinuance of Pediacof has seldom been required. Mild drowsiness occurs in some patients but, when cough is relieved, the quieting effect of Pediacof is considered beneficial in many instances.

Precautions and contraindications: Patients with tuberculosis or those who are known to be sensitive to iodides should not be given Pediacof.

Caution should be exercised if Pediacof is administered to patients with cardiac disorders, hypertension or hyperthyroidism.

Warning: May be habit forming.

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who were the "untreatables"?

From their inception with cortisone, to the present-day variants of the steroid molecule, the corticosteroids have presented a therapeutic paradox. The beneficial action against inflammation and allergy as well as several undesirable metabolic effects are all, apparently, the results of the same basic physiologic action.[1]

Some of these associated metabolic reactions made it risky or otherwise undesirable to treat with steroids large numbers of patients in various categories who would otherwise have benefited from such management. These "untreatables" were overweight, had cardiac disease, hypertension, or pulmonary fibrosis associated with congestive heart failure. Also in this category were those patients whose emotional symptoms were aggravated by earlier steroids.

But the advent of ARISTOCORT® Triamcinolone in 1958—the result of biochemical and pharmacologic research which successfully stripped away many important undesirable hormonal effects from the primary anti-inflammatory action—dramatically changed this picture. This steroid did not overstimulate the appetite, or cause the excessive weight gain induced by other steroids;[2-7] it proved to have one of the best records of any steroid for *not* causing edema, or salt-and-water retention;[2,3,7-10] and the incidence of undesirable euphoria with this agent was remarkably low.[2,4,5,9,10] What is most significant is that these benefits have stood the test of more than 5 years of widespread use. And, of course, the avoidance of these distressing hormonal effects benefited *all* patients requiring steroids, not just those in the special categories, as demonstrated by wide clinical use.

Side Effects. Since it may, under some circumstances, produce any of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.

Contraindications. While the only absolute contraindications are tuberculosis and herpes simplex, there are some relative contraindications (peptic ulcer, glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

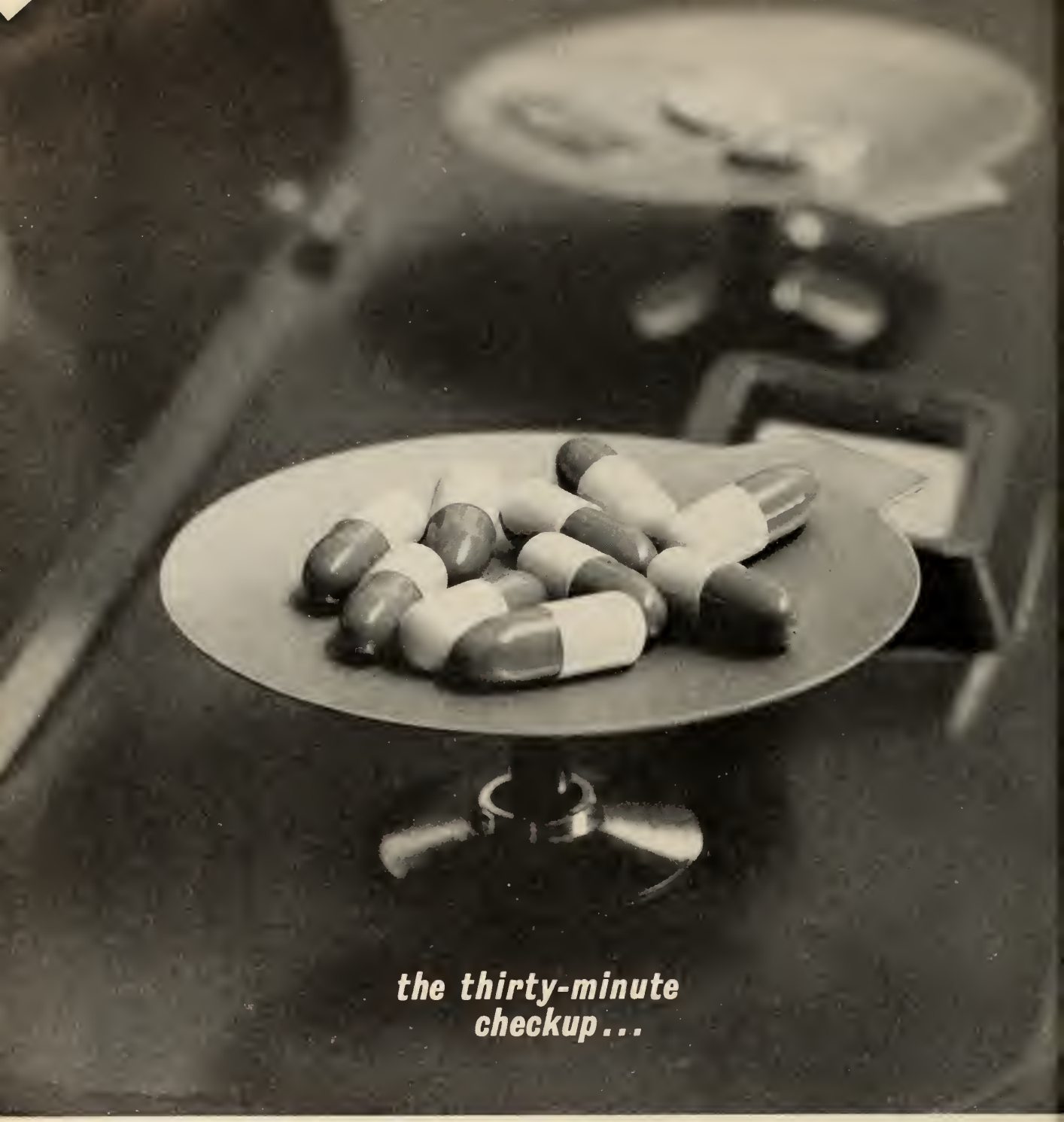
While no steroid can *cure* a susceptible disorder, many patients who would otherwise be confined in a state of invalidism have, on ARISTOCORT® Triamcinolone, been able to pursue active, useful lives.

References: 1. Levine, R.: Rationale for the Use of Adrenal Steroids, Paper presented at Annual Convention, Medical Society of the State of New York, New York, May 13-17, 1963. 2. Hollander, J. L.: Clinical Use of Dexamethasone. *JAMA 172*:306 (Jan. 23) 1960. 3. Boland, E. W.: Chemically Modified Adrenocortical Steroids. *JAMA 174*:835 (Oct. 15) 1960. 4. McGavack, T. H.: The Newer Synthetic Adrenocortical Steroids in Therapy. *Nebraska Med. J. 44*:377 (Aug.) 1959. 5. Freyberg, R. H.: Berntsen, C. A., Jr., and Hellman, L.: Further Experiences with Δ1, 9 Alpha Fluoro, 16 Alpha Hydroxyhydrocortisone (Triamcinolone) in Treatment of Patients with Rheumatoid Arthritis. *Arthritis Rheum. 1*:215 (June) 1958. 6. Cahn, M. M. and Levy, E. J.: Triamcinolone in the Treatment of Dermatoses. *Amer. Practit. 10*:993 (June) 1959. 7. AMA Council on Drugs: New and Nonofficial Drugs. *JAMA 169*:255 (Jan. 17) 1959. 8. McGavack, T. H.; Kao, K.-Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: Clinical Experiences with Triamcinolone in Elderly Men. *Amer. J. Med. Sci. 236*:720 (Dec.) 1958. 9. Fernandez-Herlihy, L.: Ill. Use and Abuse of Corticosteroid Therapy—The Structure and Biologic Activity of the Corticosteroid Hormones and ACTH, *Med. Clin. N. Amer. 44*:509 (Mar.) 1960. 10. McGavack, T. H.: Triamcinolone: A Potent Anti-inflammatory Sodium Excreting Adrenosteroid. *Clin. Med. 6*:997 (June) 1959.

maximum steroid benefit—minimum steroid penalty

Aristocort®
Triamcinolone
1 mg., 2 mg. or 4 mg. tablets

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Empty capsules are filled by the finest precision machinery available . . . but no machine is perfect. That's why all Lilly Pulvules® (filled capsules) are given the "thirty-minute checkup" to be certain that uniformity is maintained. At least once every thirty minutes ten filled capsules are taken from each machine and carefully weighed on a prescription balance. In addition, the checks are double-checked at least four times each day . . . another of the many stringent controls which assure you that the Lilly products you prescribe provide quality that merits the full measure of your confidence.

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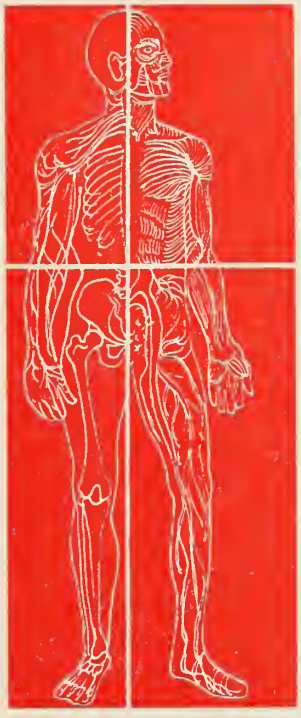
Dawn of a New Era

Theodore G. Klumpp, M.D.
New York, New York

FOR MORE than three years, the Pharmaceutical Industry had been subject to a barrage of sensational headlined charges and bad publicity. Defense never altogether catches up with a vigorously pressed attack of this kind. Nevertheless, in quiet, reasoned and carefully prepared testimony and public statements, we had succeeded, we felt, in fending off the most extreme proposals to hobble our industry. We had taken a stand favoring a number of legislative proposals and modification of others.

On August 21, 1962, the Senate Judiciary Committee reported out a bill which was no patsy but which was one that we felt we could live with. And at that point, the thalidomide incident suddenly exploded in the nation's press, although the essential facts had been known, reported and commented on for several months previously. This touched off the hysteria which resulted in a 78 to 0 roll call vote in the Senate when a far more extreme bill was substituted for the original one. I am told that a unanimous recorded vote in the Senate is a rare phenomenon. Even a declaration of war, where national unity was a consideration, failed to gain a unanimous vote.

After this amazing action of the Senate, a small committee of the Pharmaceutical Manufacturers Association went to see Senator Eastland, whom we considered a veteran level-headed moderate in political affairs. He told us that we'd better work to get a bill passed by the House in session because if we didn't, the drug bill would become the number one domestic issue in the coming election campaign. We saw the truth of what he said because one by one our friends deserted us fearing for their political lives. For example, Representative Younger of California was the author of an amendment in the House Committee bill, which in effect, implemented the proposal I had been privileged to make in my testimony concerning advertising in professional journals. When the bill with the Younger amendment came to the floor of the House and this particular section was being vigorously supported by Representative Oren Harris, Chairman of the Committee and author of the bill, suddenly Rep-





The Author
THEO. G. KLUMPP, M.D.

Presented at the annual meeting of the Michigan Clinical Institute, Detroit, Michigan, March 13, 1963.

Doctor Klumpp is President of Winthrop Laboratories, New York 18, New York.

resentative Younger got up and withdrew his amendment. Why did he publicly repudiate the paternity of his own child? I am told that he had learned that his opponent in California was accusing him of being against the drug bill in favor of thalidomide. Indeed, our own private and informal polls of voters' views disclosed that the public equated the drug bill with thalidomide. If you were against the drug bill, you were in favor of thalidomide and deformed babies.

As the 87th Congress was impatiently straining to wind up its affairs and go home, there was still a chance that the all important House Rules Committee would refuse to report out the drug bill thus killing it for 1962. We had reason to believe that a substantial but unknown number of members of this important Committee considered the drug bill a child of hysteria and therefore unsound. In deciding what course of action to follow, we had to weigh carefully what would happen to our friends if we were successful in killing the bill in that session and how much support we would be able to muster in 1963 when Senator Kefauver threatened to return to the wars in behalf of his patent and anti-trust theories. Unfortunately, our fire power in the present climate of public opinion was something less than lethal. Nevertheless, in our industry councils the debate on what course of action should be taken was fierce. The decision may have been the most crucial one we have ever made but the prevailing view was to support a bill and try to get the best one we could. How fateful this decision was we didn't know at the time but we found out three days later when the Rules Committee met to vote on the bill. The vote was six for and six against, which meant that the bill was killed for that session of the Congress. When the vote was announced, Representative Harris, author of the bill, went before the Rules Committee and announced that the Pharmaceutical Manufacturers Association supported his bill. Representative Smith, Chairman of the Rules Committee, remarked that he didn't see why the industry would support a bill as bad as this but if it did, he would change his vote. Another member changed his, and the bill was reported out by a vote of eight to four. We will never know whether what we did was right or wrong. But the fact is we have a law and we are going to have to learn to live with it, right or wrong, and we will.

Up to this point, I have focused the spotlight on some of the history of the Drug Amendments of 1962. Let us for a moment look at this event from a broader perspective. Why should the American public rise up in its wrath and clobber the pharmaceutical industry? Thalidomide produced scarcely a political ripple in Germany, where we are told that a thousand or more deformed babies were born. The reaction in England was greater but nothing compared with that in the United States. Didn't the American public know that our pharmaceutical industry led the world in the development of new drugs that raised the life expectancy from 45 years to 70 and contributed enormously to health and well being? Didn't the public know that without our drugs surgeons could not operate, and the physician would stand at the bedside empty-handed and helpless?

I think that this episode has deeper significance and implications that extend far beyond the pharmaceutical industry. In the last half-century, there has occurred the greatest scientific revolution the world has ever known. Science is king, and it has revolutionized our way of life and our standard of living. We are perching men on top of rockets and exploding them into outer space. Pretty soon our scientists will be probing the moon and the planets. Our scientists have developed atomic devices capable of obliterating mankind from the face of the earth. Ordinary people do not clearly understand these things. It would be amazing if there weren't some kind of a popular reaction to the bewildering developments of modern science. Instinctively, people fear the awesome power of the scientific genie they have let out of the bottle. They are fearful that the scientists are recklessly playing with dangerous toys and will only succeed in poisoning, maiming or killing us all.

The blind instinctive reaction to the 20th Century scientific revolution is just beginning. It may be seen in the opposition to the fluoridation of water, the stringent regulation of food additives, the growing influence of the anti-vivisectionists, the Delaney anti-cancer amendment of the Food, Drug and Cosmetic Act, the outcry against insecticides and pesticides brought to a focus in Rachel Carson's book, "Silent Spring." Recently, the government has expressed a reluctance to license vaccines when the cells of animals, classed as pets, are used as a culture medium for the growth of the organisms. I am sure that some of the distrust of our doctors arises from the same suspicion of scientists generally. Whether they were consciously aware of it or not, many practicing physicians felt overwhelmed by the greatest outpouring of new drugs the world has ever seen. Instead of stepping up their own self-education to meet the scientific revolution in drugs, they instinctively reached out to kill

the goose that was laying too many golden eggs. Certainly, the Drug Amendments of 1962 and the tough regulations flowing from them reflects a public distrust of the skill, care and prudence of the scientists and administrators of our industry and of the medical profession.

I cannot say that all of the reactions to scientific achievements are wrong. At the same time, this blind indiscriminate outcry may act as a brake on the wheels of progress. The pace of our gains against disease, disability and death may be retarded, unless we do a better job of communication and education of the professions as well as the public.

When the Drug Amendments of 1962 became law on October 10, 1962, it marked the close of one era in therapeutics, and the dawn of another. I chose the word "therapeutics" with care because the momentum of change that began in October will affect not only those who manufacture drugs, but also those who handle them, dispense them and administer them—And always in the end they will affect most, those who know least about what is happening to them, the public. We hope it will be for the better.

The old era running roughly for 56 years, from 1906 to 1962, was a fabulous period. During this time, more gains were made in the conquest of disease and the prolongation of life than in the 999 centuries of man's previous existence on earth. Our life expectancy advanced from 45 years in 1900 to 70 in 1963.

During the same period, and really in its second half, our pharmaceutical industry came from nowhere to assume world leadership. It may be that as we look back from the perspective of time, we shall recognize that this was the golden age of American medicine—which it could not have been without the contributions of the pharmaceutical industry. In all times of great change and rapid progress, there are inevitably some excesses and some false steps taken. But on balance the era we have just passed through was without question the most beneficent from the standpoint of medicine and therapeutics, experienced by any people at any time. This was the period of the loose rein.

We now enter the period of the tight rein. There can be no quarrel with most of the broad purposes of the Drug Amendments of 1962. I am in agreement with the stipulation that there should be closer supervision over experimental drugs, that there be adequate evidence of effectiveness and safety before a drug is offered for sale, that drugs should be promptly removed from the market when toxicity clearly is found to outweigh therapeutic usefulness, that every manufacturing establishment be registered and regularly inspected, that full information concerning the pharmacology, toxicity and clinical experience with drugs be available to physicians and pharmacists, and that advertising be truthful.

If all this can be achieved without intolerable side effects, then this new law will prove to be one of the most constructive steps in public protection ever taken by our Congress. But if at the same time, the development of new drugs is repressed and we lose our position of world leadership, if the testing of new drugs in the laboratory and the clinic becomes so costly that very few companies can afford it, if many small pharmaceutical houses are driven out of business, if the red tape and peril of clinical investigation becomes so onerous that many of our best clinicians abandon this endeavor, if public and professional confidence in drugs generally is undermined by excessive publicity of their side effects, if the public is led into an orgy of damage suits whenever side effects occur, if the 50 States of the Union are encouraged to enact supplementary drug legislation with varying requirements; if any of these consequences ensue, then it may well be that the net effect of the law on the public welfare will be detrimental.

The Drug Amendments of 1962 is the law of the land. Whether it turns out to be beneficent, or leads to some of the dire consequences I have outlined, will be determined by The Food and Drug Administration and how it implements the law.

I was an officer of the Food and Drug Administration when the Food, Drug and Cosmetic Act of 1938 was enacted. I recall the magnitude of the task of translating the language of the law and the Congressional intent behind it into action programs. The recently adopted legislation is much more complex, and I have the greatest sympathy for the job before the administrators of this law, surrounded as they are now with a cordon of avowed critics whose attitudes run the range of the spectrum. The position of the leadership of the FDA is not an enviable one: They will be damned if they do, and damned if they don't. More than anything else, patience on the part of legislators, the industry, the professions and the public is important at this time.

On the other hand, governmental officials do not have the benefit of consultation with the Divine. They are more dependent on outside comments, criticisms and reactions in arriving at sound and workable rules and regulations than most of us realize. With this in mind, I am taking the liberty of commenting on the

implications of some of the administrative steps already taken and regulations proposed under the new law.

In recent years, it has become fashion for regulatory agencies to require an ever increasing volume of reports and answers to questionnaires from those subject to their authority. The old-fashioned regulatory procedure was to suspect a violation of the law on the basis of information and belief and go after it, leaving others undisturbed and in peace. Today's technique is to require everyone to furnish voluminous operational reports or to subpoena the records and documents of a company or even an entire industry in the hope that somewhere in this material there will be found self-incriminating evidence of a violation of the law. No one knows whether or not all this information is read, or just filed away. It is hard to see what restraints there are to prevent an agency from creating an ever increasing mountain of useless paper work and screaming to the Congress for ever increasing funds to handle it. During World War II, my company was obliged to fill out a long and time-consuming questionnaire. A few months later we were again asked for essentially the same information. When we protested, we were told that the original questionnaires had been shipped to a warehouse in St. Louis and that it was easier to ask for the information again than to try to dig it out of the warehouse. The second Hoover Commission had a task force on "paper work" which showed then that the Federal Government was spending 4 billion dollars a year on paper work. Each year, government bureaucrats write more than 1 billion letters which cost the taxpayer one dollar each. Studies demonstrated that savings of at least 100 million dollars a year to government and private industry were possible through better cooperation between the two in eliminating unnecessary paper work. On all sides, inside and outside of the government, it is recognized that excessive paper work is the curse of big government. From all indications, the situation continues to grow worse rather than better.

It is my earnest hope that the Food and Drug Administration will exercise the greatest restraint in calling for reports, carefully weighing the purpose they will serve against the time and effort called for on the part of industry and clinical investigators, as well as the manpower resources available to gain a maximum of useful information from them. In the March 1963 issue of *Fortune Magazine*, Lawrence Lessing estimates that the Food and Drug Administration will be asking for from 300,000 to 500,000 reports a year. As the Hoover Commission suggested, it would be a wholesome thing for all branches of government to intensify programs of evaluating and auditing the ever mounting burden of paper work. Experience teaches that such audits are most useful when done by an outside, independent group.

The FDA's conception of how the new law should be administered is being gradually revealed. It gives us cause for concern. In addition to the paper work problem, the FDA appears to be employing the new drug section of the law as a censorship device whereby every change however minute and insignificant, in the composition, labelling and claims made for a new drug on the market must have prior approval and clearance.

At the same time, any such changes in an old drug may convert its status into that of a new drug, touching off all the rigmarole of a new drug application. In my opinion, the FDA goes too far in this respect. It creates for itself an enormous chore of unnecessary red tape and it discourages and delays change. The essence of progress is change. I think it is impossible for the FDA to make the myriad of small day by day decisions that are inherent in the research and marketing activities of each member of a complex and progressive industry. The industry should be permitted to assume the responsibility of making most of the decisions in this area. If companies make mistakes, there is effective authority in the rest of the law to correct them promptly by warnings, seizure, criminal charges, and even injunction action. Furthermore, I have serious doubts that the medical and technical staff of the FDA is sufficient, qualitatively and quantitatively to take on this enormous load. I am aware of the fact that the agency has hired a large number of new medical officers. I know from experience that it will take a long time, perhaps years, to train these men to make the necessary decisions in this difficult area. They are badly needed and will have plenty to do without bringing in personnel to do a job that industry should be doing for itself.

The medical officers of the FDA are confronted with a grave dilemma. They have the responsibility of approving new drugs as safe, and yet they know as well as you and I that only after years of widespread use can one be certain that a new drug, like a new airplane, is safe. As one governmental officer put it: "When a medical officer of the FDA receives a gold medal from the President for not approving a new drug, when he is confronted with the possibility of Congressional hearings, condemnation by newspaper and Grand Jury proceedings, if a drug turns out to be toxic, any medical officer who releases a new drug ought to have his head examined." This may be an

extreme statement, but in it is reflected the nature of the dilemma, and it is real.

It has been suggested that when a real problem exists, or where a manufacturer feels that his new drug should not be rejected or held up further, that he may request the designation of a panel of experts to advise the medical officer, or officers responsible for the decision. This proposal has been spelled out in detail and is available for anyone who wants to consider it further. The advantages to the public, the FDA and the industry of such a step are so self-evident that I am at a loss to understand why it was not written into the law. It deserves the attention of the Food and Drug Administration.

In recently proposed regulations, the Food and Drug Administration has declared its intention of pre-censoring pharmaceutical advertisements "if use of the drug *may* cause fatalities or serious damage." The basis for this decision is that part of the law which reads, ". . . except in extraordinary circumstances, no regulation issued under this paragraph shall require prior approval by the Secretary of the content of any advertisement."

Now, as physicians, you know that there are very few potent drugs that may not cause fatalities or serious damage. This, then, is bold governmental censorship, a practice which since the founding of our Republic has been considered repugnant to the ideals of liberty and the freedom of the press. However, in fairness, I must tell you that it is not the first step taken in this direction. The Securities and Exchange Commission censors the official prospectus of stock offerings but this is a single document like the officially approved brochure accompanying the introduction of a new drug. But, here we have proposed for the first time all the delays and red tape inherent in governmental pre-censorship of all advertisements for the drugs involved. With ample power to stop, punish and even send to jail manufacturers who publish false or misleading advertisements, pre-censorship with all its evils, would hardly seem necessary to protect physicians from the guile of the pharmaceutical industry. It can only be based on the theory that practicing physicians are helpless, gullible and badly informed.

I would be surprised if the tradition, dignity and self-reliance of a great profession would permit it to passively accept this point of view.

There are other respects in which the Food and Drug Administration appears to be going farther than the law calls for. The law requires advertisements to contain a brief summary relating to side effects, contraindications and effectiveness. It says nothing about the relative prominence of these elements of an ad. However, the FDA proposes in regulations that there be a "fair balance" in prominence among these constituents of an ad. The words "fair balance" mean that one element must not outbalance another in prominence. How one can headline a simple claim and give balanced prominence to its oftentimes multiple contraindications and possible side effects, is beyond me. This requirement violates all the principles of good advertising. Physicians won't read advertisements that are cluttered up with printed matter like an insurance policy. And if they don't read them, we can't afford to continue to advertise. Besides, this requirement is really unnecessary because the medical profession has full information about the drugs we advertise, in every package insert, and in the official brochure available to them.

The above are two examples of the extremes to which the FDA proposes to go in applying the provisions of the new law. I won't burden you with a recital of others that are similarly objectionable. From all of this, you may gain some idea of why I chose the title, "Dawn Of A New Era," for this presentation.

There can be little doubt that the Drug Amendments of 1962 were passed to protect physicians and the public from harmful drugs. Doctors know better, but I'm afraid that the Congress and the public expect more than this or any law can deliver. As long as we have drugs, motor cars, airplanes, and even bicycles, we will have accidents and the development of flaws that only time and widespread use will reveal. There is a hazard in everything we do and it is right that we should take all reasonable steps to minimize those hazards. But, in the field of drugs, we are now entering an era in which we are excessively pre-occupied with safety. It can seriously interfere with the more important objective of providing the tools to alleviate the ills that still afflict mankind. In the end, we can lose more than we will gain. The philosopher, Alfred North Whitehead, so wisely said, "Panic of error is the death of progress."

Observations on Fluorescent Staining for the Detection of Acid-Fast Organisms In Sputa and in Tissues

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THE ACID-FAST PRINCIPLE utilizing a fluorescent dye seems to have been first utilized in the United States by Tanner in 1941[1] who reported highly favorable results. Despite this and a few subsequent studies, the method has never found favor among bacteriologists who were devoted to tuberculosis. The reasons are not entirely clear but it is probable that adequate light sources and optics were not readily available and that morphological detail was not sufficiently good to permit identification of acid fast bacilli with confidence. Cost of equipment was probably a second major consideration because the care of the chronically ill has always been beset by poverty. The present renewal of interest in the method stems from the spectacular success of the fluorescent antibody technique which has placed highly effective equipment in many laboratories. With the appearance of Truant's[2] restudy of fluorescent staining* and the elaboration of a simple and reliable technique, the existing equipment at the Herman Kiefer Hospital was turned to an appraisal of the method as applied to routine sputa and surgical specimens, subsequent to some preliminary exploration which was essential to gain familiarity with the appearance of the tubercle bacillus in its new guise.

Sputa

Methods.—The routine examination of sputa in this laboratory consists of homogenization in HCl, centrifugation and preparation of smears and culture of the sediment. Smears are stained by steaming carbofuchsin, and acid Fast-Green dye. To this routine was added a smear stained with auramine and rhodamine (AR) according to Truant's directions.** The results of ZN and AR staining and culture appear in Table I. All cultures were observed over a period of at least ten weeks. There were 1,001 specimens, after having discarded those showing contamination.

Results.—Of the 1,001 specimens, 202 from 102 patients proved positive by one or more of the three methods, namely ZN smears, AR smears and culture. Item "6" is the most significant, showing that 51 of the 202 positives were obtained by the fluorescent stain alone, or about a fourth. Item 7 reveals clearly that positive cultures can be expected in about a fifth of specimens negative by both the ZN and AR stained smears. In four specimens, the ZN stain revealed organisms when both fluorescent staining and cultures were negative. Item 5 shows an additional gain by fluorescent staining, this and the cultures being positive with 19 when the ZN smears were negative, or about one tenth of the positive specimens. Culture failed with 13 specimens when both ZN and AR stains were positive.

*Wellmann and Teng have thoroughly reviewed the literature.[8]

**A study of tuberculous lesions by means of the fluorescent-antibody technique was under way in this laboratory when we became aware of Doctor Truant's investigation of direct fluorescent staining at the Henry Ford Hospital. Doctor Truant most generously made his experience available to us and we were able to install his technique without difficulty which is here reproduced.

Solutions

1. Auramine and Rhodamine
   Auramine "O"—15 gms. CI 41,000 Allied Chemical Corporation
   Rhodamine "B"—7.5 gms. CI 4517 Allied Chemical Corporation
   Glycerol—750.0 mls.
   Phenol (melted crystals)—100.0 mls.
   Distilled water—500.0 mls.

The stain solution was combined and mixed for 24 hours on a magnetic stirring device. The stain was stored in a

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Tissues

The results of acid-fast stains on sectioned tissues do not lend themselves to a statistical presentation because no two cases are quite alike. A variety of lesions often occur in the same specimen. Active and inactive disease may exist side by side and even a single caseous lesion may be well encapsulated and arrested in one portion and actively extending in another. Moreover, we were never comparing identical but only similar lesions when smears and sections from tissue were stained by the ZN and AR methods, respectively.

It has been common knowledge since Koch that the demonstration of acid-fast bacilli in sections of *human* tissue is highly unsatisfactory. For a long time, the only satisfactory control material possessed by this laboratory came from a rhinoceros. At least one pathologist, Oberling as we recall, in one edition of his *Précis d'Anatomie Pathologique*, had the temerity to call the effort a waste of time. Smears from tuberculous material are much more often productive but even here the price in time and effort is exorbitant. Only during the acute phase of a (human) tuberculous lesion when neutrophils are numerous can bacilli be readily demonstrated. As macrophages become predominant, there is a drastic reduction in the number of organisms and as the lesions become proliferative and caseous, bacilli become progressively more rare until a rather ill-defined point is reached where the experienced pathologist no longer bothers to look for them. From the beginning of tuberculosis bacteriology it has been known that tuberculous material is infectious for laboratory animals in the apparent absence of organisms and this fact has produced a vast literature which embodies among other considerations the idea of a submicroscopic form. Loss of acid fastness seems today the only valid preoccupation and applies both to ZN and AR staining, this and the profound alterations in virulence to animals and in growth capacity in culture which have been introduced by modern therapy.

TABLE I

	Z-N	A-R	Culture	
	O	O	O	= 814

The following 202 specimens were submitted by 102 patients:

	Z-N	A-R	Culture	
1.	+	+	+	= 70
2.	+	+	—	= 13
3.	+	—	+	= 1
4.	+	—	—	= 4
5.	—	+	+	= 19
6.	—	+	—	= 51
7.	—	—	+	= 37
	Contaminated cultures			= 15
	Atypical AFB:			
	—	+	+	= 1
			TOTAL:	202

Method.—Surgical specimens in this laboratory are examined routinely under sterile conditions, blocks for paraffin sections selected and material obtained from what appear to be the most recent lesions. The latter are submitted to the bacteriologist who minces the material thoroughly and prepares smears and cultures. The present study was entirely retrospective, paraffin blocks being recut and stained by the fluorescent method on specimens which had produced negative

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stoppered flask and small amounts were filtered just before use.

2. Decolorizer
   0.5% HCl in 70% ethyl alcohol.
3. "Counter-stain"
   0.5% $KMnO_4$ in distilled water.

Staining Method

The smears of sediments were stained at 37°C. for 15 minutes followed by washing in water. Destaining is effected with acid alcohol for 1-2 minutes followed by washing in water and further treated with potassium permanganate solution for two to three minutes followed by a wash in water. The $KMnO_4$ serves to clear the sections of non-bacterial fluorescence. The action is quite drastic and should not be over-done.

Fluorescent Equipment

The Zeiss photomicroscope was employed exclusively. The accessories we employed were a cardioid condenser, BG 12/3 mm. exciter filter in conjunction with a heat absorbing filter and two barrier filters. The two latter are inserted into a slot in the tube head and are changed at will by sliding the holder back and forth.

The barrier filter used for scanning smears was the OG5 (Zeiss). This filter allowed the bacilli to fluoresce with a bright orange color and was characteristic of the bacilli retaining the auramine dye. By changing to a GG4 (Zeiss) filter the bacilli exhibited a red color which indicated retention of the rhodamine dye. This is an important feature of the method. Artifacts capable of causing confusion are rare. Unless these fluoresce with both auramine and rhodamine they can be dismissed.

For rapid scanning of smears, the planachromat 25/0.45 (N.A.) objective was employed. The planachromat 40/0.63 (N.A.) objective usually rendered sufficient definition of morphology to identify the bacilli with certainty. The Apochromat 100/1.25 (N.A.) oil immersion objective with an iris diaphragm was valuable to study the morphology of bacilli when lower powers left one in doubt.

Tissues were embedded in paraffin and sectioned as usual. Staining was identical to that outlined for smears (except at temp. 56°). Coverslips were mounted with Harleco synthetic resin. Fluorescence of the resin and the tissue was negligible.

Interpretation

One must rely upon morphology as with the ZN stain. Granules and probable fragments are disregarded. In sections a search is often required to find organisms properly oriented for good viewing. When a typical organism can be found it is always possible to find two or four. Anything less is best recorded negative.

smears. Preliminary studies had shown that whenever ZN smears were at all positive, the fluorescent technique nearly always revealed numerous organisms in sections. None of the 55 consecutive specimens has as yet yielded growth in cultures although at least two months have elapsed since surgery. Cultures are retained for nine months and within this period a few can be expected to become positive.

Results.—Among 55 surgical specimens from known cases of tuberculosis furnishing ZN negative smears, 28 were positive by the AR method or 51 per cent.

The types of lesions which yielded positive results accorded well with what one would expect from their histological character. A few discrepancies remain unexplained. Nearly all the lesions showed an advanced degree of regression but where a well developed epithelioid reaction persisted about caseous lesions, organisms were usually found without difficulty. A certain number of caseous lesions with acellular capsules and even early calcification yielded a few organisms. A few active cavities with ZN negative smears got into the group. AR staining showed numerous bacilli except in two. Where active disease existed in the absence of demonstrable acid-fast bacilli, we suspected the intervention of another pathogenic agent such as Histoplasma capsulatum.

Generally, the lesions that had lost the specific histological characteristics of tuberculosis, such as old cavities lined by granulation tissue, were negative by the AR method. Likewise, a considerable number of stable fibrocaseous lesions were negative. In one case of healed tuberculosis with residual fibrosis and bronchiectasis, bacilli were quite numerous. It is suspected but not proved that these were acid fast saprophytes. In another specimen where the changes consisted of fibrosis with extensive foci of lymphocytic infiltration, scattered acid-fast bacillary forms were readily demonstrated. The existence of bacilli in lesions of this kind was known to early workers but was probably demonstrated only by inoculation.[4]

Bacilli have been demonstrated in epithelioid tubercles, twice in lymph nodes showing lesions that could pass for "sarcoid." This raises the ghost of an ancient controversy and is being made the subject of a separate study.

Discussion

In situations where acid-fast organisms are relatively few, the AR fluorescent technique yields a substantially greater number of positive results than the ZN stain on both smears from sputa and on pathological sections. Because slides can be quickly scanned with a 25x objective and a positive decision made with a 40x objective, the saving in time is enormous. When one is interested in the relation of organisms to the various components of a tuberculous lesion, the AR stain will remain at a disadvantage until a technique is found to render the details of tissue structure visible without destroying the chief virtue of the method, namely, a nearly black field against which a bright object can scarcely escape notice. When organisms are numerous as in a tuberculous pneumonia the advantage is with the ZN stain which gives a little better view of the details of morphology than does a fluorescent stain and at the same time serves as a histological stain.

One can anticipate that fluorescent staining will become popular only in laboratories handling a considerable volume of tuberculous material, for two reasons. First, the interpretation of AR stained preparations requires a considerable amount of practice even though these are remarkably free from confusing artifacts. However, it is probable that no more errors would occur with the AR method in relatively inexperienced hands than one is already accustomed to seeing with the ZN stain. The second consideration is the high cost of equipment. The chief items are the light source and provision for quick changes at the microscope of the barrier filters. Probably a reasonable solution can be found in modifications of the simple equipment that was used by the early workers with fluorescent stains.

Conclusion

Fluorescent staining by the auramine-rhodamine technique combined with modern instrumentation represents a major advance in the bacteriological diagnosis of tuberculosis. The method is equally applicable to exudates and histological sections.

Acknowledgments

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Septic Abortion With or Without Septic Shock

Diagnosis and Treatment

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CASES of threatened or incomplete abortion, with or without associated septic shock, currently are a major problem in Michigan, and in some other states as well. In 1961, the most common direct cause of maternal death in Michigan was obstetrical infection, and over the 12-year period, 1950 through 1961, there were 162 reported deaths from infection, 84 (52 per cent) of which were from septic abortion.[1] Study of the anonymous case record abstracts of maternal deaths from septic abortion, collected by the Michigan Department of Health, reveals that while these cases come from all parts of the state, by far the majority occur in the large metropolitan areas. The problem is a large one, on a relative basis, and therefore it must claim the attention of the physicians of our state who practice any obstetrics, particularly those who live in or near the metropolitan areas. These physicians should familiarize themselves, if they have not already done so, with the newer knowledge of the nature, detection, and treatment of septic shock in cases of abortion.

A recent study of septic abortion at Detroit Receiving Hospital revealed an increased number and incidence of such cases there in each of the years since 1957.[2] This is believed to be due to the increasing size of the medically indigent population block from which this hospital draws its patients, an apparently increasing fertility of the people in this block, and an apparent increase in the number of criminal abortions among them.[2] Most of the abortions treated in this hospital in the past three to four years have been accomplished by the passage of a small rubber male catheter up the cervical canal, and this is performed on some women by themselves, through self-palpation. In the two-year period, 1959-60, there were 662 cases of septic abortion at Detroit Receiving Hospital, and 12 (1.8 per cent) had septic shock.[2]

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Also submitted as part of the educational program of the Maternal Welfare Committee, Michigan State Medical Society.

Diagnosis

The usual woman having a septic abortion presents herself with the complaint of vaginal bleeding for two to four days, some cramps in the lower midline of her abdomen, and passage of clots and also tissue, in some cases, from the vagina. A few will tell of feverishness and chills during the past one to two days. Occasionally, they will admit to being two to about six weeks overdue on their menses, but in most instances they do not tell of having missed any "periods." We have learned not to put any importance whatever on our initial failure to obtain a history of missed menses or of intracervical instrumentation, insofar as making our working diagnosis is concerned. We go ahead without delay and treat all of them as though they were instrumental abortions, which has subsequently been found to be the truth of the matter in better than 95 per cent of our cases.[2]

On physical examination, in our experience, the temperature may be anywhere from 96.8 to around 105 degrees F., the subnormal levels usually belying the presence of severe infection and shock. It is important to bear in mind, when a woman who is having an abortion is found to have a normal temperature, that this does not preclude the presence of a potentially severe and ultimately dangerous sepsis. In some such cases, the infection has subsequently proved to be overwhelming. We have found that temperature variations may occur rapidly and with wide swings in these cases, and that it is necessary to take and record the temperature and pulse of all suspect women every four hours. Among other important physical findings in cases of septic abortion, in our experience, is a pulse rate from 100 to 160, and we have come to consider that a rate of 100 or higher is best taken as being indicative of a severe, or potentially severe, degree of infection. Given a case in which the history, symptoms, and physical findings all indicate the presence of an infected abortion, we proceed at once, despite the absence of an actual fever, with the routine taking of intracervical specimens for culture. If the

pulse is elevated to a rate of 100 to 110 per minute, or higher, we generally will commence full antibiotic therapy as well, once the material for culture has been obtained.

The respiratory rate may range from 20 to 70, and the blood pressure may be normal, or down to shock levels. The white blood cell count, in our experience, averages 20,000 to 24,000, with extremes of 4,000 and 46,000. The woman may not appear to be at all ill when first seen, or she may be definitely ill, and even moribund in some cases. Examination of the abdomen may be of special interest, in that there may be lower abdominal tenderness and, in many cases, some muscle rigidity there as well, both indicating the presence of pelvic peritonitis. If the uterus is enlarged to eight weeks of pregnancy in size, it may be palpable abdominally, and occasionally it will be intrinsically tender.

On sterile vaginal examination, there is usually a bloody discharge coming from the external cervical os, and clots and also some conceptal tissue may lie in the vagina or cervical canal. The discharge may or may not have a fetid odor, and it may be copious or scant. The cervix may be closed or open, firm or soft, normal in size or enlarged. There may be induration, thickening, and/or tenderness of the bases of the broad ligaments on each side of the cervix laterally. The tubes and ovaries may be normal and non-tender, or enlarged, tender, prolapsed to the floor of the lateral pelvic fornix and adherent. There may be definite tenderness of the cul-de-sac of Douglas, and this may indicate the presence of pelvic peritonitis; the same is usually indicated when marked discomfort is evoked by passive side-to-side movement of the patient's cervix.

In our experience, a case of abortion or miscarriage should be suspected of being infected if any one or more of the following are present: a temperature of 99.8 degrees F. or higher; a pulse of 100 to 110 per minute or higher; definite tenderness of the lower abdomen, with or without muscle rigidity; definite intrinsic tenderness of the uterus itself; tenderness of the tubes and ovaries, broad ligament bases, and the uterus; and a foul or purulent, copious discharge coming from the cervical canal.

If there is evidence of shock,[3] as may be denoted by blood pressures of 80/50, or lower, and a pulse rate of 110, or higher, and with coolness and moisture of the extremities, it may be due either to *blood loss, to sepsis, or to a combination of blood loss and sepsis.* A complete blood count and hematocrit determination are of major aid in deciding upon the main cause of the shock. Shock is most likely not on the basis of blood loss if the hemoglobin is 10 grams or higher, or the hematocrit is 36 per cent or higher. When the shock is found not to be on the basis of blood loss, it probably is due to sepsis, and in such cases it is best to bend all major treatment efforts toward the eradication of the infection, and not to give a blood transfusion until such time as this can be done without the danger of overloading the cardiovascular system, thereby possibly inducing decompensation.

Treatment

Many of these patients are dehydrated, and some may be oliguric and even anuric. Thus the first thing to do is to start an intravenous infusion of 5 per cent glucose in water. If there is any doubt about the patient's voiding her urine readily and in adequate amounts, we at once insert an inlying Foley bladder catheter and connect it for continuous drainage, also starting recordings on a fluid intake and output chart. If there is any reason to suspect imbalance of the fluid and electrolyte levels, blood chemistry studies are made as soon as possible, including the potassium, sodium and chloride values, and the blood pH and CO_2 percentage values. We ordinarily repeat the hematocrit determination after the first 500 to 1,000 mls. of intravenous fluids have been administered, so as to guard against a falsely high original finding which might have been due to the patient's dehydration.

As soon as the intravenous fluid administration has been started and the sample of blood has been withdrawn for study, we perform a sterile speculum vaginal examination, and take specimens for culture from the cervical canal. If there is vaginal discharge over the cervix, we first remove it with a sterile cotton ball, and also remove whatever discharge or conceptal tissue there may be in the external cervical os. We then insert a sterile, cotton-tipped applicator stick well up in the cervical canal, twist it back and forth, and carefully remove it without fouling it against any part of the vaginal tract or vulva. The culture stick is placed in a tube of culture broth, or into a sterile, empty tube, and these are taken to the bacteriological laboratory for planting as soon as possible. If these culture specimens dry out or otherwise die before they are properly planted, the most important and crucial guide to the best means of saving the woman's life may have been lost. We request routine cultures and *in vitro* antibiotic sensitivity testing on all strains grown, and ask for a report on these findings as soon as the results can be determined. In addition to inoculating a culture with the material taken from the cervi-

cal canal, we prepare slides for immediate staining and examination.

As soon as the culture specimens have been taken, antibiotic therapy is commenced by adding indicated amounts of penicillin and chloromycetin[4] to the bottle of intravenous glucose solution, in the more ill patients, and streptomycin is injected intramuscularly. If the woman is very sick, we will add 3 to 20 million units of intravenous penicillin and 2 to 3 grams of chloromycetin to the bottle of intravenous fluid and have it run in as a slow drip over a period of from 6 to 12 hours. A second liter of glucose solution containing the same amount of antibiotic agents can be given in the second 12-hour period, as the needs of the case may dictate. If the woman is not very ill, the penicillin and streptomycin should be injected intramuscularly twice daily, and chloromycetin capsules (250 mgms. each) should be given at the rate of 2 every 6 hours, so as to provide a dosage of 2 grams per day. The intramuscular daily dose of penicillin in such cases is usually 2 to 8 million units, and 1 to 2 grams of streptomycin is usually an effective dose.

If the patient's hemoglobin is less than 10 grams, we give one or two 500 ml. units of blood intravenously in the first 12 to 24 hours of hospitalization. We check the hemoglobin level every three days in order to learn if additional blood should be administered. We also do white blood cell counts with differential determinations every three to four days in order to see how well the patient is mounting a defense against her infection. We also want to be sure that the chloromycetin, or any other antibiotic medications being given, are not causing a suppression of her white blood cell production.

If the patient is in some degree of shock, and the hematocrit is lower than 30 to 34 per cent, we will give a 500 ml. blood transfusion as rapidly or slowly as the needs of the situation require. We would hope to bring her "up" out of shock with this transfusion and hold her blood pressure just above shock levels during its administration. If her hematocrit reading was very low and her shock of marked degree we would start a second blood transfusion and give it simultaneously with the first one. But care must be exercized not to over-transfuse these cases, as such may be done very easily and quickly. If a fair rate of blood administration to a "bled out" and febrile woman does not relieve her shock state, it may be on the basis of septic shock as well as blood loss.

During fluid and blood administration, it is important to auscultate the patient's lung bases frequently in order to detect the first moist rales which may signal the beginning of pulmonary edema.

In a fatal case recently reviewed by the author, a woman died of infected abortion with septic shock 21 hours following admission to the hospital. Her actual death was from pulmonary edema and cardio-respiratory failure, and it occurred 45 hours following the first onset of fever and chills. In reviewing the total intravenous fluid administrations, it was found that she had received 1,000 mls. of blood and 3,800 mls. of intravenous glucose during her 21 hours in the hospital, all of which was given, along with its contained antibiotic agents and pressor agents, by slow intravenous drip. It was given in an effort to maintain her just above shock levels of blood pressure, but in the meantime she developed pulmonary edema and died. She *might* have survived if less intravenous fluid had been given, as her weakened cardio-respiratory system might not then have been over-taxed. On the other hand, her shock was combatted by all means available, including continuous nasal oxygen, and death may well have been inevitable regardless of what was done.

In an occasional case of severe septic shock, it may be impossible to keep the patient out of shock despite the administration of intravenous fluids, including blood as indicated, and massive dosage with antibiotic agents, and it may be necessary to give an antihypotensive agent such as metaraminal bitartrate (Aramine), or, in the more severely shocked patient, levarterenal bitartrate (Levophed). These should be administered by very slow intravenous drip, and must be very closely watched by a physician. He should take and record the blood pressure every hour, at the least, and adjust the rate of dosage so as to just keep her blood pressure above shock levels if possible. As soon as it appears that she might get along without the agent, he should try discontinuing it for half an hour or so, and see if it is possible for her to do so; it should be discontinued as soon as the patient's condition permits.

We have done a dilatation and curettage in about 95 per cent of our patients in order to remove any remaining conceptal tissue from the uterine cavity. Ordinarily we do not do this until after 18 to 24 hours of antibiotic therapy has been accomplished, but will do it sooner in the face of more than average bleeding or some other extenuating circumstances.[2] If the uterus is relatively large and soft, and the bleeding is more than average, we may also give an intravenous "drip" of pitocin solution, using 1 ml. in 500 to 1,000 ml. of 5 per cent glucose in water. If there is high fever, we usually delay the dilatation and curettage until a high

level of antibiotic agents has been maintained in the blood stream for from six to 12 hours.

We usually do the dilatation and curettage under local anesthesia, injecting 10 mls. of a 1 per cent solution of xylocaine beneath the mucosa at 3 and 9 o'clock on each side of the cervix, first having given 100 mgms. of demerol intramuscularly. If the cervical canal is fairly widely open, we may evacuate it of its contents with the ring or "ovum" forceps under demerol analgesia alone. Only occasionally do we perform the operation under inhalation anesthesia, and then only when the patient cannot or will not cooperate sufficiently to allow us to do it under local. Many of these women are so ill as to be very poor inhalation anesthesia risks, and the local anesthesia technique permits emptying of the uterus without additional risk to the patient. We always use the ring forceps to evacuate the uterus, and may follow it with a large and dull curette, but we do not use a small or sharp curette for fear of puncturing the uterus.

In cases in which the cervix is fairly firm and is closed, we may, upon inserting a cervix dilator, open up a retention pyometra. We dilate it far enough to permit all the purulent material to drain out, and use only blunt instruments to remove any retained conceptal tissue. We leave a gauze pack in a cervix or uterus only very rarely, and then only when there is appreciable bleeding, following evacuation of the uterus, even with an intravenous pitocin "drip" running. Such gauze is removed in 6 hours unless there are unusual extenuating circumstances.

One of the most important aspects of treatment is to recognize that the basic pathologic state is infection, and thus the most important element of the therapy is the administration of antibiotic agents in adequate amounts. The infections in some cases are so severe, and progress with such rapidity that no time can be lost in getting the material for culture and starting the antibiotic therapy purely on an empirical basis. If the patient is still alive by the time the culture and sensitivity reports are available, then her antibiotic therapy can be modified as indicated. Antibiotic therapy and general supportive care are continued until the patient has been afebrile for from 72 hours to 7 to 10 days, depending upon her general condition, how sick she has been, and upon how rapidly the findings on pelvic examination return to normal.

Summary

1. Septic abortion has accounted for 57 per cent of the maternal deaths from infection, as a direct cause, in Michigan in the past 12 years, and infection was the most common direct cause of maternal death here in 1961. The problem of septic abortion should be the concern of all physicians who practice any obstetrics or gynecology.

2. The important points in any case of infected abortion are: early recognition, the prompt taking and planting of intracervical cultures, then the immediate institution of adequate antibiotic therapy, and the replacement of lost blood and the administration of proper amounts of intravenous fluids and electrolytes.

3. Since the shock in these patients may in a few cases be caused by the sepsis rather than the blood loss, such must be recognized as soon as possible lest the patient be over-transfused and thrown into a state of cardiac decompensation. In such cases infection is the basic cause of the shock, and it must be treated aggressively with adequate doses of penicillin, streptomycin, and chloromycetin. When the culture report and the sensitivity test results are at hand, other antibiotic agents may be given as indicated.

4. Dilatation and curettage of the uterus is usually done under local anesthesia and demerol analgesia, and may be performed 12 to 24 hours after antibiotic therapy has been commenced unless brisk bleeding requires that it be done sooner.

5. Anuria with acute renal failure must be watched for, and fluid and electrolyte balance must be maintained. Care must be exercised not to administer more intravenous fluids than the patient's cardiovascular system can properly handle, lest pulmonary edema be so induced.

6. When the administration of intravenous glucose, blood, and continuous nasal oxygen fail to bring a patient out of shock, an antihypotensive agent may be given. Its administration by slow intravenous drip must be closely checked by a physician, and he should take and record her blood pressure every hour, discontinuing the drug just as soon as she can get along on her own without it.

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Traumatic Petit's Hernia Repair Using Tantalum Mesh

Case Report

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IT IS PECULIAR that hernias through the inferior lumbar triangle of Petit are so infrequently reported. The area is potentially weak anatomically, is frequently traversed by the surgeon's scalpel, or may be weakened by an abscess draining through the area or damaged by trauma. The first reported case was by Petit in 1738, who described a strangulated hernia through the inferior lumbar triangle that now bears his name. In 1866, Grynfeltt described the superior lumbar triangle; prior to his report, all lumbar hernias were assumed to come through Petit's triangle. In 1946, Flickinger and Mason collected only 16 cases from the world literature,[3] including a bilateral case of their own, that had been surgically repaired. Hafner, Wylie, and Brush were able to find 19 additional cases, including two of their own. They repaired one case with fascia lata, and reported on a method of repair using Marlex mesh.[6]

Anatomy

The triangle of Petit is bounded anteriorly by the posterior border of the external oblique muscle, posteriorly by the anterior edge of the latissimus dorsi muscle, and inferiorly by the crest of the ilium. The floor consists of the lumbar fascia, the internal oblique muscle, and the transversalis fascia or transversus abdominal muscle. Through this triangle, herniation may occur; either through a congenital defect, or as a result of acquired attenuation of the normal structures.

Symptoms

The diagnosis of a hernia through the inferior lumbar triangle of Petit is similar to the recognition of hernias in other locations. A soft, easily reducible mass is present in the lumbar region. This usually transmits an impulse on coughing or straining. There may be no other symptoms. Occasionally, patients may complain of pain on coughing or increasing intra-abdominal pressure. Some complain of a vague dragging sensation in the loin, or have gastrointestinal symptoms. Hernias of this type are apparently more common in men.

Diagnosis

The diagnosis depends on finding a soft mass in the posterior axillary line, just above the iliac crest. The mass is usually easily reduced, and transmits an impulse with coughing. Pain in the area transmitted to the hernia is often reported when the patient coughs. Occasionally, bowel sounds are heard over the herniation, or a tympanitic note found on percussion, or a gurgling sound heard when the hernia is reduced. In the differential diagnosis, subcutaneous lipomas, cold abscesses, Pott's disease, paralytic scoliosis, hematomas, primary or metastatic neoplasms, muscle herniation, or fibromas must be considered.



Fig. 1. Anatomy of the lumbar region. Line of vertical incision for repair of hernia through Petit's triangle indicated.

Treatment

If the hernia is symptomatic, and there is no medical contraindication, herniorraphy is indicated. Many of the cases in the literature were recorded before surgical technique was safe, hence trusses and supports

were indicated and advised. Owen in 1888 reported on the first repair of Petit's hernia. He inverted the sac and approximated the muscles over the defect with catgut. In 1894 Bull excised the hernial sac in a young child

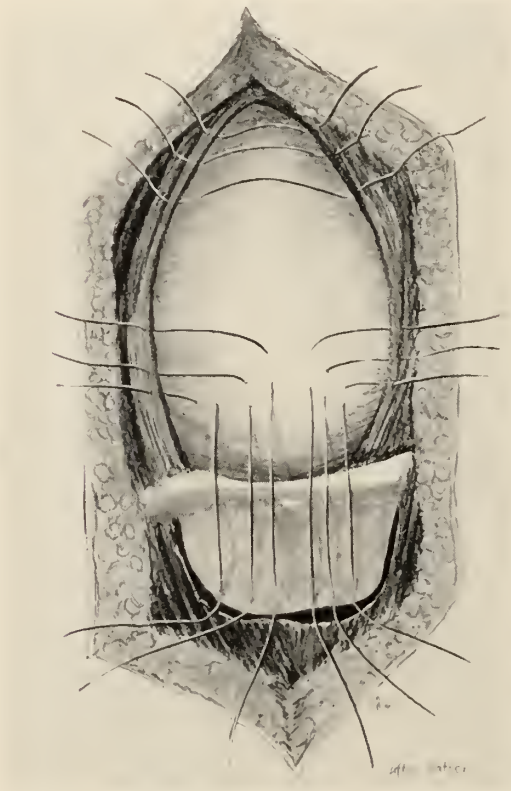


Fig. 2. Operative technique of Dowd, utilizing fascial flap from gluteus muscles.

with a congenital hernia, and closed the deep structures with kangaroo tendon. In 1907, Dowd described a method of repair incorporating a flap of fascia lata from below the ileum that is turned upward upon its base and sutured to the lateral muscle borders and the floor of the lumbar triangle.[2] In 1917 Rishmiller[6] suggested turning a flap of the aponeurosis of the latissimus dorsi anteriorly over the flap of fascia lata to further reinforce the closure. Because the structures in this area do not lend themselves to precise anatomical reconstruction, reinforcement with autogenous or synthetic material has been reported.[4]

Case Report

On November 23, 1948, a 52-year-old underground iron ore miner was struck by falling ore. He sustained a comminuted fracture of both bones of the left leg and a bruise of the back. A cast was applied to the leg, holding the fragments in good position. Further x-rays of the back showed a moderate compression fracture of the second lumbar vertebra with some reduction of the lumbar curve. For this he was placed in reverse position on a hospital bed, in a hyperextended position. This he tolerated surprisingly well. Despite the considerable comminution, the leg healed rapidly. A back brace was not applied to the back as the patient was using crutches, and the vertebral deformity was minimal. On December 31, 1948, the patient first noticed a small, soft mass in the posterior aspect of the right flank just above the iliac crest. This was noted on the hospital progress notes as a possible lipoma or small fibroma. He was discharged to his home, using crutches, and seen in the office at weekly intervals. The patient reported on April 16, 1949, that the lumbar mass had increased in size. Examination revealed a mass the size of an orange that was easily reduced, and had a distinct impulse on coughing. The anterior edge of the external oblique muscle could be palpated as a definite edge; the crest of the ilium easily felt. On further visits, the patient complained that coughing produced a pain in the hernia, and

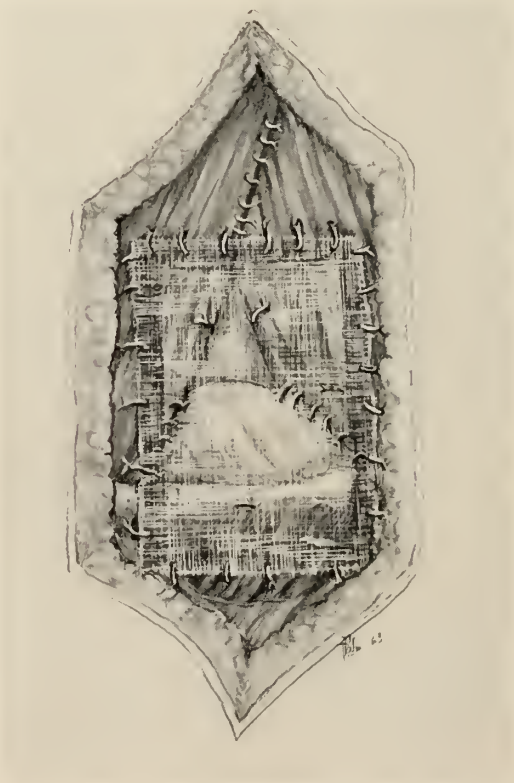


Fig. 3. Tantalum mesh reinforcing the hernia repair and covering the defect in the fascia over the gluteus muscles.

that he often had vague pains in the lumbosacral area, which were referred to the hernia.

On October 16, 1949, a Petit's herniorraphy was performed. With the patient on his left side, a vertical incision of 10 centimeters in length was made over the central portion of the mass. A defect of approximately 4 centimeters in diameter was found above the iliac crest and posterior to the posterior edge of the external oblique muscle. The latissimus dorsi

formed the posterior border of the defect. The anesthetist caused the patient to strain, and the floor of the triangle bulged upwards. Blunt dissection through the weak transversalis revealed loose areolar tissue, and it was felt that further dissection in an attempt to find a definite sac was not indicated.

Summary

A case of traumatic hernia of Petit's lumbar triangle with surgical repair utilizing tantalum mesh has been presented. This procedure was done in 1949, and no evidence of recurrence by 1963 has been noted.



Fig. 4. *(left)* X-ray appearance of mesh after five years. Mesh intact and conforming to body contours.

Fig. 5. *(right)* X-ray appearance after 13 years. There is partial fragmentation of the metal mesh, but the major portion of the mesh is intact.

The external oblique and latissimus dorsi muscles were approximated at the apex of the triangle with interrupted catgut sutures. A flap of fascia lata overlying the gluteus muscles was lifted and folded superiorly on its base at the iliac crest to cover a portion of the defect, as suggested by Dowd, and sutured to the edges of the muscle edges. The aponeurosis of the latissimus dorsi was found to be very thin, and apparently would add nothing to the repair. The need for additional support was apparent, and because of his leg injury further surgical insult to obtain fascia lata was not thought advisable. A piece of tantalum gauze measuring approximately 10 cm. in diameter was cut, the edges folded over, and sutured to the latissimus dorsi and external oblique muscles, superiorly, and the fascia of the gluteus muscles and iliac crest inferiorly. The subcutaneous tissues were approximated over the implant, and the skin closed without drainage. The postoperative course was uneventful, the patient ambulant the day following surgery, and discharged from the hospital a week later.

On November 4, 1949, he was examined in the office. The surgical wound was well healed, there was no tenderness. No cough impulse could be determined; the patient volunteered that the pain that he previously experienced in the area had disappeared. He has been seen at yearly intervals since 1949. No evidence of symptoms or recurrence have been noted. An x-ray of the area was taken on June 18, 1953, and again on March 13, 1963.

If there are no contraindications, surgical repair of Petit's triangle hernia is indicated. If satisfactory autogenous material is available, surgical repair according to the procedure advocated by Dowd is indicated. In this case, as in other reported cases, additional support was necessary. Marlex mesh has recently been used with success, and this report records a case operated upon in 1949 using tantalum mesh, with a good result.

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Raynaud's Disease and Raynaud's Syndrome

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A RECENT editorial in *The Lancet* (September 8, 1962),[1] based upon an article by DeTakats and Fowler ("The Neurogenic Factor in Raynaud's Phenomenon"),[2] tends to give the impression that a true Raynaud's disease does not exist. This impression is incorrect. True Raynaud's disease may be defined as the primary and idiopathic form of the phenomenon of paroxysmal spasm of the digital arteries producing acral ischemia and cyanosis of the digits, bilaterally and symmetrically, in response to cold and emotions; it is usually relieved by warmth. In its severe form there is a recurring, painful spasm, narrowing the local vessels, deforming the digits (usually the fingers), and leading to local ulceration and necrosis. The disease is frequently seen in young women who show other evidence of vasomotor instability.

Raynaud's syndrome, on the other hand, is due to paroxysmal spasm of the digital arteries, always as the result of some underlying vascular or other disease. Most common of the underlying diseases are the obliterative vascular diseases (arteriosclerosis obliterans and thromboangiitis obliterans), the collagen diseases (scleroderma, rheumatoid arthritis, dermatomyositis), thermal injury (frostbite and burns), mechanical trauma (use of vibrating tools such as the pneumatic hammer), and the Naffziger syndrome (cervical rib and scalenus anticus syndrome).

Raynaud's syndrome may also result from lesions of the central nervous system.

The use of the preceding definitions obviates the rather meaningless term "Raynaud's phenomenon," which requires qualification, and which serves, in my opinion, more to confuse than to enlighten.



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In the 15-year period subsequent to July 1, 1934, over 350 patients were given a diagnosis of Raynaud's disease or questionable Raynaud's syndrome at the University of Michigan Hospital.[3] In order to confirm the diagnosis of Raynaud's disease and to secure an adequate follow-up period only those cases studied between July, 1934, and July, 1946 (a 12-year period), were included in this investigation. No case was included in whom the disease had not existed five years or more, in order to rule out underlying disorders prior to making a diagnosis of primary Raynaud's disease in one hundred of these patients.

There were 77 females (77 per cent) with true Raynaud's disease and 23 males (23 per cent). All cases included were followed for a minimum of five years. Follow-up information in 83 cases (83 per cent) covered from 11 to 55 years. In 70 per cent of cases the symptoms remained more or less stationary. In 12 (12 per cent), the symptoms regressed over a period of years or disappeared altogether. In these patients, classed as more or less stationary, the symptoms were often relieved in the summer months or when residing in warm climates during the winter months. The symptoms were re-exacerbated by exposure to cold, especially during the winter months or when working in cold water during the summer. Relief could be obtained from an attack by immersion of the hands in warm water. Attacks could be made less frequent and less severe by careful attention to keeping the hands warm and, in many cases, by the avoidance of emotional crises. In perhaps 15 to 20 per cent of cases

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some degree of improvement was obtained by the administration of thyroid extract and correction of secondary anemia, if present. Some of the patients in this series were benefited by the ingestion of Priscoline while others were not. All of the 69 cases classed as essentially stationary obtained some measure of relief by adherence to the preceding principles of therapy.

Six patients (6 per cent) experienced definite progression of their symptoms to a point short of ulceration and necrosis of the finger tips, and to a point at which, in spite of increased frequency of attack and increased pain and disability, they would not yet submit to dorsal sympathectomy.

One-quarter (25 per cent) of the patients in this series progressed to a point at which necrosis, ulceration, and gangrene of the finger tips (in 11 cases, 11 per cent of the total series), or pain and disability required dorsal sympathectomy.

Twenty out of 40 patients undergoing dorsal sympathectomy had marked relief of their Raynaud's disease following operation for at least two years. Ten of these patients, who had relief for from four to 15 years, were available for tests for sudomotor activity. One-half of them showed some degree of sweating of the palms during these tests. Angiospastic phenomena were demonstrated in three patients who had no sudomotor activity. There was an interesting correlation between the type of dorsal sympathectomy performed and these results.

In general, recurrences were noted earlier in the patients having the preganglionic type of operation, and indeed, in a few of these relief was not even obtained immediately after operation. The five patients with Raynaud's disease who showed no sudomotor activity on later study (and of whom three had residual although ameliorated angiospastic activity) had all had postganglionic sympathectomies. Two had had excision of the stellate ganglia as well.

Recurrences were associated with demonstrably active vasomotor nerve fibers (regenerated pre-ganglionic axones). The ideal operation is one which will completely denervate the extremity and at the same time prevent regeneration. Appropriate glanglionectomy and intraspinal section of the pre-ganglionic innervation minimizes the chances for regeneration.

The prognosis then, for patients after dorsal sympathectomy, is excellent for relief of symptoms providing complete denervation is accomplished. Vasomotor phenomena may persist even in the total absence of sudomotor activity and this fact strengthens the theory of the role played by local faults or hypersensitivity in the pathogenesis of Raynaud's disease.

Anyone who has studied a large number of these cases is impressed by the infinite variety of related symptoms and signs and by the fact that immediate diagnosis and prognosis in an early case is fraught with hazard. I have seen Raynaud's symptoms precede the onset of scleroderma by as long as a year or two, although the two diseases appear to be no more related than are Raynaud's disease and rheumatoid arthritis. The history of overexposure to cold and of chilblains in youth is frequently elicited in patients, especially those who have grown up on a farm. It is sometimes almost impossible to rule out frostbite as the cause of the symptoms. However, if over an adequate time interval the patient presents the symptoms of true Raynaud's disease and the history of frostbite is not overly convincing, then this diagnosis seems justified.

There are three clinical types of patients with Raynaud's disease: those whose symptoms are precipitated by cold alone, those in whom both exposure to cold and emotional upsets precipitate attacks, and those who while sensitive to cold have an extremely prominent functional element. In my experience, patients of the first type usually have the least difficulty as avoidance of exposure to cold prevents attacks. Further, they do not often progress to a point at which tissue is lost, providing that they take good care of themselves. The last group has the most difficulty, usually experiencing attacks all through the summer months or in warmer climates. Patients in this group are much more likely to progress to loss of tissue or to dorsal sympathectomy for relief of severe incapacity. Unfortunately, these patients appear to have the poorest post-operative results, regardless of whether sympathetic denervation is and remains complete as shown by tests for sudomotor and pilomotor activity.

DeTakats and Fowler have found that in some patients whose disease appears to be neurogenic in origin and in whom abnormal electroencephalograms are obtained, the results of surgical therapy are good.

In summary, caution should be exercised in the diagnosis and treatment of Raynaud's disease and Raynaud's syndrome. When sympathectomy is really indicated, the operation should be radical.

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ALBERT E. HEUSTIS M.D., State Health Commissioner

Michigan's Premarital Law

In recent months, a considerable amount of interest in Michigan's premarital law has been generated as a result of alleged misconduct by two laboratories in Detroit. This flurry of activity in the press and elsewhere serves to point up and to re-emphasize legal aspects relating to the issuance of a medical certificate as required by law to all those planning to be married in Michigan. These are, of course, of particular significance to the physicians in the state who are the only ones empowered to certify that a person is free of syphilis, gonorrhea, or chancroid.

The law itself is quite specific. Act 207 of the Public Acts of 1937 as amended by Act 112, P. A. 1939 and Act 230, P. A. 1945, required that all persons making application to marry shall within thirty days prior to such application be examined as to the existence or non-existence in such persons of any syphilis, gonorrhea, or chancroid. The law adds that all laboratory tests required by this act shall be made by the Michigan Department of Health or a laboratory which is registered by the department, and goes on to say that if, on the basis of negative laboratory and clinical findings the physician in attendance finds no evidence of venereal disease, he shall issue a certificate to the examinee to that effect on a form prescribed by the Michigan commissioner of health.

This is a good law, one which has been taken as model by many other states in the nation. It is a law which was designed to protect the marriage partners, themselves, from exposure to venereal disease and, perhaps more important, to protect an unborn child from being born into the world with one of these preventable diseases.

However, there is an apparent need for more stringent rules and regulations for the application of the premarital law, and the department has already presented such proposals to the Council of Health for approval. In effect, some of these proposed rules and regulations would help to clarify the responsibility of physicians with regard to the premarital law.

Whereas the present law clearly specifies a serologic test for syphilis, it does not establish any standards for the physical examination. To establish such standards the department has proposed that the examination under the premarital physical examination law shall consist of not less than the following:

SYPHILIS:

Physical examination for the presence or absence of skin or mucous membrane lesions.

GONORRHEA:

1. The examination of the genital tracts of both the male and female for clinical evidence of gonorrhea.
2. If clinical evidence is present, a specimen shall be submitted to an approved laboratory for examination.

CHANCROID:

Examination of the genitalia and anus for the possible presence of chancroidal lesions. If such lesions are suspected, smears shall be taken and submitted to an approved laboratory to determine the presence or absence of the Ducrey bacillus.

Other proposals would require that each laboratory performing tests under the premarital law must have the written request of a licensed physician to perform such tests; that the Medical Certificate for Marriage License (Form V-90) be distributed only to licensed physicians by county clerks, and directors of full-time local health departments; and that the results of tests performed under the premarital physical examination law be submitted only to the physician requesting the tests except that the results of positive or reactive tests would also be reported to directors of full-time local health departments or (in areas without such a department) to the state commissioner of health in accordance with Regulation 1-A of the venereal disease rules and regulations.

The basic intent of the department in proposing additional rules and regulations regarding application of the premarital law is to make it easier for physicians to carry out the intent of the law, as well as to strengthen their position in relation to the laboratory of their choice. Certainly, in the face of a rising incidence of venereal disease, especially in the age group from 15 to 20, it is incumbent upon us all to do everything possible to prevent the further spread of such disease.

Wm. J. Burns

By E. I. Carr, M.D.
Lansing

1933 was a critical year, critical for the nation and critical for the Michigan State Medical Society. I was chairman of the Legislative Committee and J. Milton Robb, M.D., of Detroit, was president of the State Society. The committee was large and composed of some of the most important doctors of the state, all dedicated to the responsibilities of the committee and responsive to the many and frequent demands.

Medical representation in legislative matters, up to this time, had always been too casual and, when carried on, was done by hit and miss. Wayne County saw the need and generously offered the full-time services of their recently employed lay secretary to the State Medical Legislative Committee as an assistant to its chairman. Thus Bill Burns became my guest and associate continuously in Lansing from February to June of that year. A broad acquaintance for Bill resulted.

The need for a full-time secretary of the State Society was becoming acknowledged and in another year William J. Burns became the choice. He rapidly grew into the institution of Bill Burns.

He arrived at our house with his Roget's Thesaurus under his arm. Together, we courted the lawmakers, we barnstormed the state, we wrote articles and created an intimacy which was endured through the years, and led to many associations not only at home but abroad.

Bill Burns, the man! He can do a facsimile of anything or anybody. He excels in mimicry of style, in signatures, in writing speeches, in reporting for committee chairmen, to mention only a few. He is creative in office organization, second to none—a pattern for many states. He pushed some doctors through their responsibilities of office, covering up inexperience, ineptitude or lack of time, if required, but principally and essentially he has aided the conscientious and made hundreds of difficult jobs easier.

I think his outstanding characteristic is that he credits

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doctors for almost every plan or thought that arises from his experience and thinking.

He has always been so chuck-full of ideas that, except for the quality of his integument, he would have burst. Fern Foster once said, "Bill, what is going to happen, when you run out of ideas?" Bill's answer, "I'll be out of a job."

How thirty years of habit can stop abruptly by voluntary resignation is beyond my imagination—habit by his performance, habit by our dependence upon it. Pattern and spirit will remain as will inexpressible gratitude.

Continued satisfaction and happiness for Bill, Jo and Missie is our earnest wish.

(Note: Mr. Burns has retired after nearly 29 years of service as executive director of the Michigan State Medical Society. His new address is Sky Harbour East, 2100 S. Ocean Drive, Fort Lauderdale, Florida, which is headquarters for his own business as a medical convention and exhibit director.)

Suggested Ground Rules for Beginning "Alcohololologists"

By Richard C. Bates, M.D., Chairman
MSMS Committee on Alcoholism

1. Don't start therapy until the patient has been dry for a few days and is able to maintain sobriety for several days at a time. If he can't do this, hospitalize him.

2. If he has been drinking all day and every day for a week or more, hospitalize him, use heavy sedation for the first few days, then withdraw sedatives gradually over the next three to six days.

3. If at all possible (and with the patient's permission) visit with his wife, employer, minister or priest, probation officer, A.A. sponsor, social worker, parents and any and all other people who have a direct interest to him. Weave a nest of people who can support and contain him until his wings are able to carry him.

4. Use sedatives on out-patients only if you can be reasonably sure the dose will not be increased to produce a synthetic drunk.

5. The goal is absolute life-long sobriety.

6. Once sobriety has started, help the patient to live happily without alcohol. Identify sources of his unhappiness and teach him "the serenity to accept the things he cannot change, the courage to change the things he can and the wisdom to know the difference."

7. The physician must think of himself as dealing with an impulsive, immature but worthwhile adolescent. The physician's proper attitude, then, is one of firmness, kindness and expectation that, despite occasional lapses into unacceptable behavior, the general course will be toward increasing maturity with proportionate rewards in praise, freedom, trust and affection being offered by all hands as progress is made.

8. When the patient shows feelings of guilt and remorse and when he's increasingly concerned about others (his wife and family, his employer, other alcoholics) he's making progress. When he's whining about his hard lot in life, complaining about his aches and pains, boasting of his exploits and prowess as a drinker he's still too self-centered to be happy and serene.

Fitting Tribute

By Wm. A. Scott, M.D.
MSMS, 4th District Counselor

More component societies might follow the recent action of the Berrien County Medical Society.

The Berrien physicians two years ago established a Berrien County Medical Society Loan Fund. A leader in the move was Donald W. Thorup, M.D., who died recently. As a fitting and appropriate tribute to Doctor Thorup, for many years a member of the MSMS House of Delegates and the Blue Shield Board of Directors, the Berrien Society voted "that $500 be transferred from the general fund to the Loan Fund in memory of Doctor Thorup."

In its short two-year history, the Berrien fund has grown with contributions of $25—the recommended amount—from 22 Society members and one non-member.

MSMS Centennial Series

1933-34 Was Busy Time for Society With State and Federal Legislation

By William J. Stapleton, Jr., M.D.
MSMS Historian

Detroit, Michigan

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963 number and will continue through August, 1965.*

1933

In 1933, in spite of bank closings and financial problems the Society entered in its worthwhile program of providing for the wants of its members. The MSMS membership climbed slightly, and doctors again were given a rebate in their dues from $10 to $8.75 for the year.

The Grand Rapids depository for MSMS funds was one of the first Michigan banks to resume full banking business. However, the Society's balance was at a low figure by reason of nonpayment of 1933 dues. Practically all county society secretaries had collected dues and they were frozen by the bank holiday.



J. M. Robb, M.D.
President

The State Legislature was busy with many health bills. An osteopathic proposal to permit osteopaths unlimited practice of medicine and surgery passed the House and Senate but was vetoed by the Governor. A bill to provide for a Board of Chiropractic Examiners and for the licensing of applicants was approved. A malpractice bill, which posed a direct threat against the medical profession, died in committee. The Wayne County Medical Society had a legislative representative in Lansing. A special meeting of the House of Delegates was held in Lansing to receive a report of the Survey of State Medical and Health agencies. Among the findings was the discovery that instead of a plethora of doctors in the state, there was not a sufficient number to take care of the work that should be done in the way of periodic health examinations and private preventive medicine and care. Wayne County held a one-day public clinic in November in an effort to help return to the physician the preventive medicine practice that was being conducted more and more by health officers and school physicians.

The postgraduate work of MSMS and the University of Michigan Medical School continued, with courses offered in pulmonary tuberculosis, diseases of metabolism, diseases of the heart, ophthalmology and otolaryngology, proctology, practitioner's course, gynecology, obstetrics, roentgenology, serology, clinical microscopy, and physical therapy.

The following was the work of the County Societies, as reported in The Journal:

"1. Enrollment of every eligible member and maintaining his active interest in the County Society.

"2. Formulation of local principles and policies.

"3. Establishing and maintaining relationship and contact with local authorities and establishing agreements and rules to be observed in all matters pertaining to local health and public welfare.

"4. By contacting local authorities, arrive at an agreement as to conditions that will govern the rendering of medical care to wards of your city or county.

"5. Public education in regards to health.

The Author
WILLIAM J. STAPLETON, JR., M.D.
MSMS Historian



MEDICAL LIBRARY

"6. Participating and advisory interest in all community projects and activities and assuming leadership in everything related to health and medical care.

"7. Conducting county meetings and clinics that will aid your members to remain abreast of scientific progress.

"8. Assert collective influence in administrative affairs of local hospitals and clinics."

An educational highlight was the address by Professor Walter B. Cannon, of Harvard, who as the "annual Beaumont lecturer" in Wayne County helped to mark the 100th anniversary of the publishing of Beaumont's epoch-making work on the physiology of digestion.

The Annual Meeting was held in Grand Rapids when the House of Delegates voted to divide the Upper Peninsula into two Councilor Districts. . . . Child hygiene classes were conducted by many county societies. . . . The Upper Peninsula Annual Meeting was held in Escanaba. . . . About 300 heard about thyroid diseases and related conditions at the Detroit College of Medicine and Surgery Alumni Association Clinic. . . .

A State Emergency Welfare Relief Commission was organized and a medical fee schedule was adopted.

J. M. Robb, M.D., of Detroit, was the MSMS President for 1932-1933.

1934

A MSMS Mutual Health Service plan brought national attention to the State Medical Society. The Michigan plan incorporated the following:

1. Free choice of physician by the patient.
2. Limitation of benefits to those who belong to the plan.
3. Control of medical service benefits by the profession.
4. The exclusion of individuals or organizations that might engage in health insurance for profit.

The following principles were cited to be observed in any plan:

1. The immediate cost of medical service should be borne by the patient if able to pay at the time the service is rendered.
2. Medical service must have no connection with cash benefits.
3. There should be no restrictions on treatment not formulated by the medical profession.

THE JOURNAL MSMS for July reports that in Michigan alone, over 6,089 inches of newspaper space was devoted to presentation and discussion of the plan. Twenty-seven editorials appeared in the lay press. From every section of the country requests for copies of the proposed plan arrived. Most requests praised the MSMS for devising the plan. The fall House of Delegates meeting adopted the following resolution: "The House of Delegates shall postpone action on health insurance, continue the Committee on Medical Economics, and shall hold itself ready for special call, if and when any national or state program of health should appear imminent."

After the annual meeting, J. D. Bruce, M.D., of Saginaw, helped MSMS secure a grant from Mr. Tracy McGregor for the work of the MSMS Committee on Medical Economics. Later, Doctor Bruce was requested to aid in obtaining an additional grant—which was accepted from the Twentieth Century Fund of New York.



GEORGE L. LEFEVRE, M.D.
President

It seems odd now to read the following account in the July issue of THE JOURNAL:

"Detroit has been the place of meeting of two national medical associations during the same week. The American Institute of Homeopathy and the National Eclectic Medical Association held their annual meetings during the week June 18-27. The American Institute of Homeopathy was founded 90 years ago. The sessions were concerned with problems of a social and economic nature as well as methods of practice peculiar to each."

Both groups are gone now.

F. L. Warnshuis, M.D., resigned in July as MSMS Secretary after holding the position for 21 and one-half years. B. R. Corbus, M.D., of Grand Rapids, was designated as Acting Secretary.

Events on the 1934 calendar included an all-day demonstration of medical participation in public health at the Herman Kiefer Hospital, Detroit . . . The Annual Conference of County Secretaries in Ann Arbor . . . Diagnostic medical clinics at the Detroit College of Medicine and Surgery Alumni Day . . . The Upper Peninsula meeting at Ironwood . . . The MSMS Annual Meeting in Battle Creek . . . And the joint meeting of the Michigan Tuberculosis Association, the Michigan Trudeau Society and the Michigan Sanatorium Association met in Ann Arbor, heard a report that 35,000 persons were tuberculin tested and over 7,000 x-rayed during 1934.

George L. LeFevre, M.D., Muskegon, served as president.

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Explains Michigan Aspects of Federal Mental Health Law

By William H. Kelly, M.D.
Assistant Director,
Michigan Department of Mental Health

New Federal legislation that provides a significant step toward inaugurating a new era in the approach to this country's mental health was signed into law by President Kennedy on October 31, 1963.

The legislation (Mental Retardation Facilities and Community Mental Health Centers Congressional Construction Act of 1963) authorizes a total of $329 million. This includes $150 million in matching grants over the next three years for the construction of community mental health centers which can radically reduce the population of large centralized public mental institutions. It also includes funds of $126 million over a five-year period for the construction of research and treatment facilities for the mentally retarded, and $53 million for three years for the training of teachers of the mentally retarded and other handicapped children.

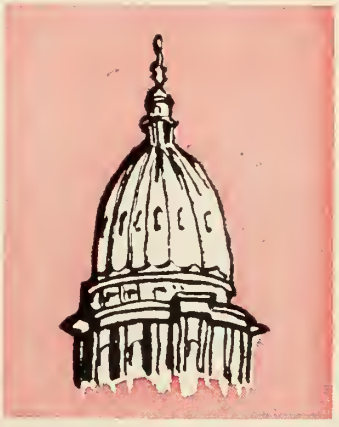
Under the section on community mental health centers, the Congress has authorized—not "appropriated"—$150 million to be spent over a three-year period in the states. The first portion of the money —if appropriated—will be available in July 1964 for the fiscal year 1965.

The State of Michigan should be entitled to about $6 million for mental health centers, during the fiscal years 1965, 6 and 7. Under the section of the bill, which authorizes sums to fight mental retardation for the fiscal years 1965, 6, 7 and 8, Michigan will be entitled to about $2.6 million to build state centers for the retarded. The total for Michigan will be about $8.6 million, over a four-year period.

All the Federal money must be matched by the state, the formula differing state-by-state, with the Federal money varying between 66 2/3 per cent and 33 1/3 per cent. The architects of the assistance program have been thinking of centers costing in the area of about $1.5 million. They would serve populations of about 100,000 and would provide seven services: (1) diagnostic services; (2) inpatient services; (3) day or night care; (4) 24-hour emergency walk-in clinics; (5) sheltered workshop; (6) consultative and educational services; and, (7) supervision of foster home facilities.

The centers would be open for use by private physicians, both psychiatrists and general practitioners. Non-profit groups can qualify for the Federal assistance and build a center. Cities, counties and voluntary associations can also qualify, as well as the states. The President, in his February message, said he hoped that many of the centers would be attached to general hospitals.

The centers *need not* be one structure. They can be clusters of services in a community—providing that each part of the service is within easy commuting distance of the others. In this regard, it is entirely possible that the Michigan aftercare services and the network of clinics, providing diagnostic, treatment and consultation services, could be worked into divisions of comprehensive treatment community mental health centers. The existing large state hospitals could also be



brought into service in one, several or all seven capacities as community intensive treatment centers.

Planning for community centers is an integral part of efforts to achieve this program in all the states. Matching funds of $4.2 million were previously provided by Congress for state-wide planning both in the fiscal year 1963 and the fiscal year 1964. Fifty-three states and territories are carrying out individual mental health planning activities with these funds. The Michigan Department of Mental Health received a grant of $137,000 under this program with which it launched, in 1963, a two-year long-range comprehensive planning project as a guide for the future development of a total mental health program for the state.

Under the Mental Retardation Facilities and Community Mental Health Centers Congressional Construction Act of 1963, the state plan must designate a single state agency for the administration of the plan, or as the sole agency for supervising the administration of the plan, and finally, any project approved for Federal assistance shall conform to the state plan.

Too often a cancer of the tongue is assumed to be an obstinate canker sore and is neglected by the patient until it has reached considerable size.

Coming In February

The February issue of THE JOURNAL of the Michigan State Medical Society will consider several clinical problems. The problem of residual or recurrent common duct stones will be presented with sphincterotomy offered as a solution. Dr. Robert A. Green discusses both laboratory and clinical experiences with atypical or unclassified mycobacteria, including methods for their identification, and case reports of their pathogenicity. An interesting article on arteriovenous fistulae sheds light on the mechanism of development of sub-acute bacterial endocarditis. A hospital administrator, Dr. Roger Nelson, discusses the need for close working relationships between hospital administration and the medical staff, and Dr. M. P. Bentley of Cadillac provides practical everyday information of use to any physician who may be asked for advice by visually handicapped people. More information on alcoholism and a good review of the routine prenatal chest x-ray, including an evaluation of radiation hazard, will also be in this issue.

Recent reports suggest... insulin and sulfonylureas may accelerate lipogenesis,[1-5]... serum "insulin" levels are often elevated in obese diabetics[2,3,6]... DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

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In the ketoacidosis-resistant obese diabetic not amenable to diet alone, hypoglycemic DBI (phenformin HCl) appears to help avoid weight gain or reduce adiposity, factors which otherwise tend to make blood sugar control more difficult and to increase the likelihood of complications. However, in the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic agent.

Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

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Editorial Comment

"One in Three Britons Wants Out!"

California Medical Society Newsletter,
September, 1963

One in three Britons would prefer to pay his own way for medical services provided he was given a lower tax to pay for his share in funding National Health Services.

This wish to opt out of NHS was given voice in a survey of British opinion on welfare services published in *Medical News*, an English tabloid circulated to the medical profession.

The survey, conducted among 2,005 male heads of households of various social classes and political beliefs, found that one-third of the respondents believed the state should continue the present health service but should allow people to contract out, pay less in contributions and use the money saved to pay for their own doctor and other medical services.

These views were expressed by 40 per cent of Conservatives, 36 per cent of Liberals, and 27 per cent of Socialists.

According to the article, 18 per cent of those questioned did not know that everybody had to pay NHS contributions or that private medical care insurance plans (called "schemes" in the article) existed. And one out of three replying believed that the NHS compulsory contributions covered the whole cost of running the service.

One out of five had insurance covering private medical care (including the same percentage of Socialists) for such reasons as additional benefits, freedom from anxiety, quicker treatment and privacy.

Although the cost of social services in Britain has grown fifty-fold in as many years (80 million pounds in 1910 to 4,230 million in 1961), the article points out, no one had ever before attempted to ask the customers whether they were getting what they wanted.





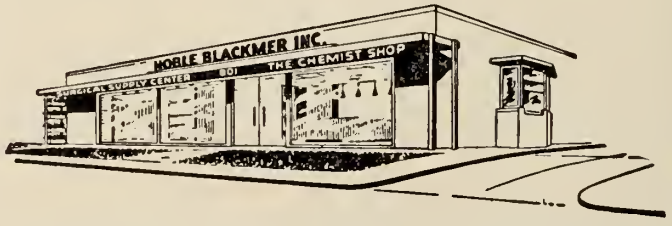
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Comments About "Level of Practice"

Dear Doctor:

I have your recent inquiry regarding the interpretation of the phrase "level of practice in your community" as indicative of the legal requirement of proficiency of the doctor of medicine.

Let me say at the outset that I think that the phrase "level of practice in your community" should not be considered out of context but should be regarded as only one of several elements which together define the required standards of practice.

Although stated by various courts with any number of minor variations in language, I believe the standard rule of law is about as follows: A physician is required to exercise that degree of care, diligence, judgment and skill which other physicians of good standing of the same school or system of practice usually exercise in the same or similar localities under like or similar circumstances, having due regard to the advanced state of the medical profession at the time.

* * *

IT WILL BE NOTED that this legal standard related directly to current medical knowledge and practice and of course allows for a constantly changing standard. In short, I think it fair to say that the law required the physician to keep abreast of the times and keep himself reasonably informed of developments in the field of medicine.

I do not believe, however, that the courts have so altered definable standards as to entirely abandon "local standards of practice." To do so would mean holding a physician practicing in a remote rural or mountainous area where hospital facilities and technical equipment are not available to the same high standards applicable to the physician practicing in a large city with adequate hospital facilities and technical equipment.

* * *

THE SUPREME COURT of Michigan, I believe, continues to apply a standard such as that quoted above. This or very similar language is to be found in practically all of the cases dealing with the subject and, although I have not attempted to run down all the cases, I find the factor of "good practice in the community" recognized in cases as late as 1961.

I thing we must recognize, of course, that actual standards of practice are constantly growing higher and that, as a practical matter, the standard of practice in the smallest community much more nearly approximates that in the largest community, than was the case a few years ago. I think that this reflects the greater availability of post-graduate education and medical literature.

LESTER P. DODD, *Legal Counsel*



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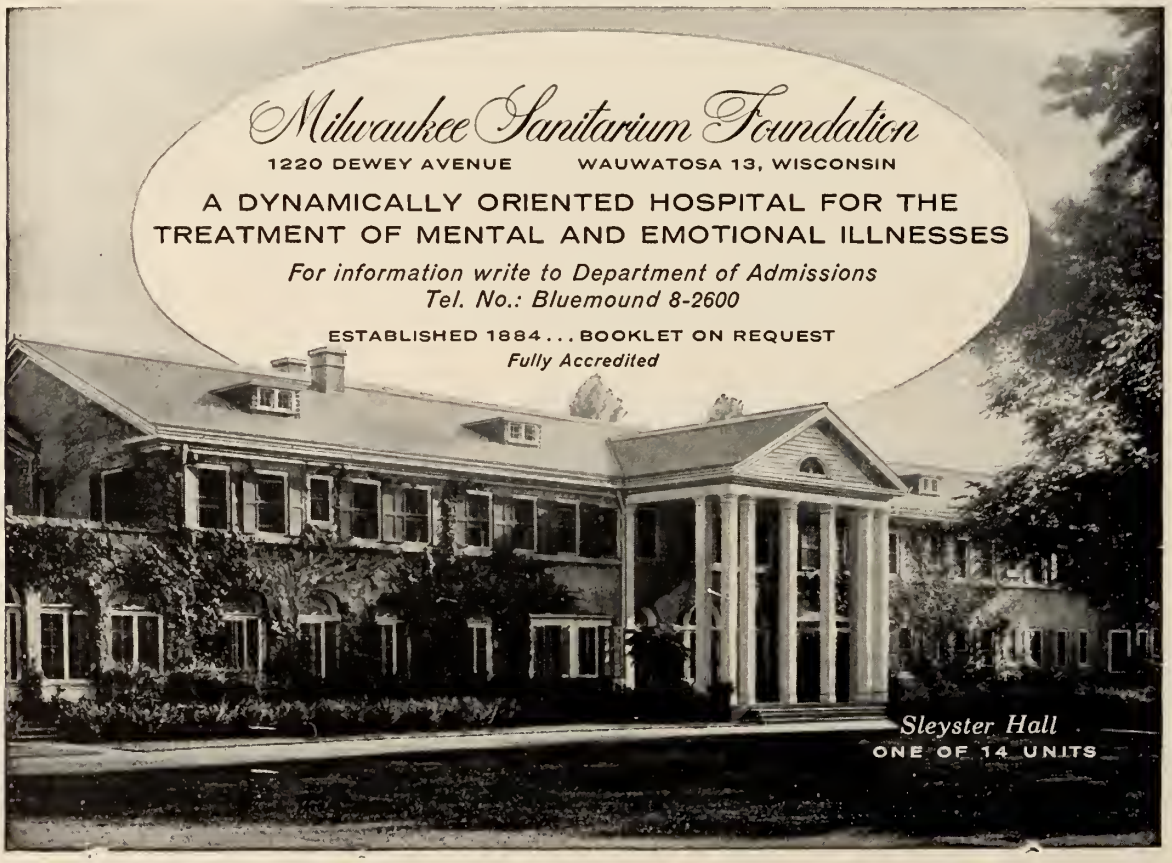
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But the Fifth Annual Congress of the Professions, February 7 and 8, in Lansing, promises to outdo all the rest:

—Never before have all of the foundations of Michigan met together in a single meeting. Most of them will be present at this one.

—Never before have the deans of Michigan colleges and universities met together at a single meeting.

—Never before have the foundations, the deans and representatives of the Professions, discussed mutual problems at a single meeting.

—Never before has there been a major conference devoted to the theme of "Money" as it relates to professional education, research and practice.

—Never before have representatives of the major professions from twenty states met together in a single Congress.

The Congress program will offer presidents of national professional societies, presidents of foundations, business leaders in the fields of insurance, pre-payment, money management, education and government. By subject category Friday, February 7, will feature "Money as related to Education"; Saturday morning, February 8, "Money as related to Professional Research"; and Saturday afternoon, February 8, "Money as related to Professional Practice."

Reservations may be made at the Jack Tar Hotel, Lansing, at once. Final programs and advance registration blanks may be obtained by contacting the Michigan Association of the Professions, 120 West Saginaw Street, East Lansing.

Heart Association to Offer Top Speakers, February 22

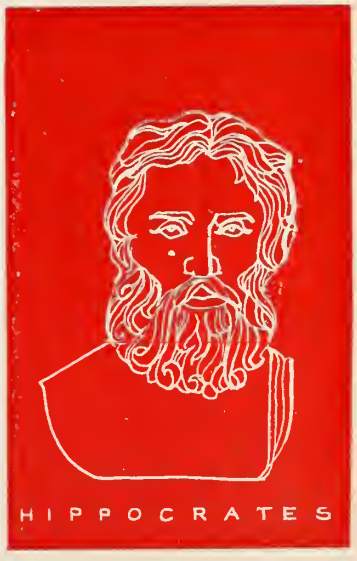
Four of the nation's leaders in clinical and laboratory heart research will speak at the Michigan Heart Association's annual Scientific Sessions at the Statler-Hilton Hotel, Detroit, starting at 9:00 a.m., Saturday, February 22.

John W. Keyes, M.D., chairman, MHA's Scientific Sessions Committee, announced the sessions have been approved by the American Academy of General Practice for six hours of postgraduate credit.

Each speaker will make a thirty-minute talk, then will participate with leading Michigan physicians in panel discussions on the same subjects.

George E. Burch, M.D., New Orleans, who will detail his findings on the influence of high humidity and temperature on coronary artery disease, and explain his new technique of phlebotomy in the management of acute myocardial infarction.

Jeremiah Stamler, M.D., Chicago, will give the latest statistics on



the development of coronary artery disease related to age groups, occupation, dietary background and smoking.

C. Walton Lillehei, M.D., Minneapolis, will discuss the relatively new field of "Artificial Heart Valves in Acquired Heart Disease."

Bruce Logue, M.D., Atlanta, will emphasize the medical treatment of arrhythmias.

Richard J. Bing, M.D., Chairman, Department of Medicine, Wayne State College of Medicine, will moderate a morning panel on Ischemic Heart Disease.

There will be two afternoon panels. The first on artificial valves will be moderated by F. D. Dodrill, M.D., Clinical Associate Professor of Surgery at Wayne State, and Chief, Thoracic and Cardiovascular Surgery at Harper Hospital.

A later panel on arrhythmias will be moderated by Jack M. Kaufman, M.D., Assistant Clinical Professor of Medicine, Wayne State, and Chief of Cardiology, William Beaumont Hospital, Royal Oak.

Doctor Stamler and F. J. Stare, M.D., Harvard University, will be the main speakers at a free public heart forum, co-sponsored again by the *Detroit Free Press* at Ford Auditorium the previous evening, Friday, February 21, at 8:00. Discussion will be controversial and include the effects of smoking and diet on cardiovascular disease, said Sidney E. Chapin, M.D., MHA President.

At the Statler-Hilton also on Friday, MHA will hold a Closed Chest Cardiac Resuscitation-O'Rama teaching session of the new and highly successful revival technique using 24 practice manikins and 12 teachers.

MHA will hold its Annual Meeting of members, election of officers, and sessions of heart unit delegates, February 22.

MCCC Speaker

The Michigan Cancer Coordinating Committee, which includes MSMS as a member, recently sent J. D. Spain, Ph.D., Houghton, to speak to the Manistique Lions Club about "Recent Developments in Cancer Research."

All Medical Assistants Invited to March Seminar

The 7th Annual Educational Seminar of the Michigan State Medical Assistants Society will be held at the Statler-Hilton Hotel on Wednesday, March 11, 1964. Approximately 250 Medical Assistants will attend.

The annual L. Fernald Foster Memorial Lecture will be presented by Ruth Campbell, M.D., Detroit surgeon. Viola Breckie, M.D., pathologist of Highland Park General Hospital, will be the speaker for the afternoon session. The theme of the Seminar will be "It's a Woman's World."

Mrs. Patricia Breen, of Merrill, Lynch, Pierce, Fenner & Smith, will speak on "Women in Wall Street."

Co-chairmen for the Seminar are Miss Gwen Whitcomb and Miss Louise Rutila of Detroit. Reservations may be made by contacting Mrs. Dolores Kobylka, 12061 Sorrento, Detroit 27. All Medical Assistants of Michigan are invited to this one-day session.

Propose New Guidelines For TB Treatment

New guidelines for intensifying tuberculosis control and treatment are being prepared as the result of a recent two-day conference at Haven Hill. The meeting was sponsored jointly by the Michigan Department of Health and the Michigan Tuberculosis and Respiratory Disease Association.



W. N. Davey, M.D.

Winthrop N. Davey, M.D., director of the tuberculosis unit of the University of Michigan Medical Center, chaired the session. Doctor Davey is a member of the eight-man U. S. Task Force to draft a similar program for the nation, appointed recently by U. S. Surgeon General Luther Terry. John L. Isbister, M.D., chief, cardio-pulmonary disease section, division of adult health, MDH, and members of his staff are coordinating activity with MTRDA staff in drafting the new proposals for submission to the Michigan Public Health Officers Association in March.

The need for assistance of private physicians in screening patients for tuberculosis was emphasized at several points during the conference by Doctor Davey and others.

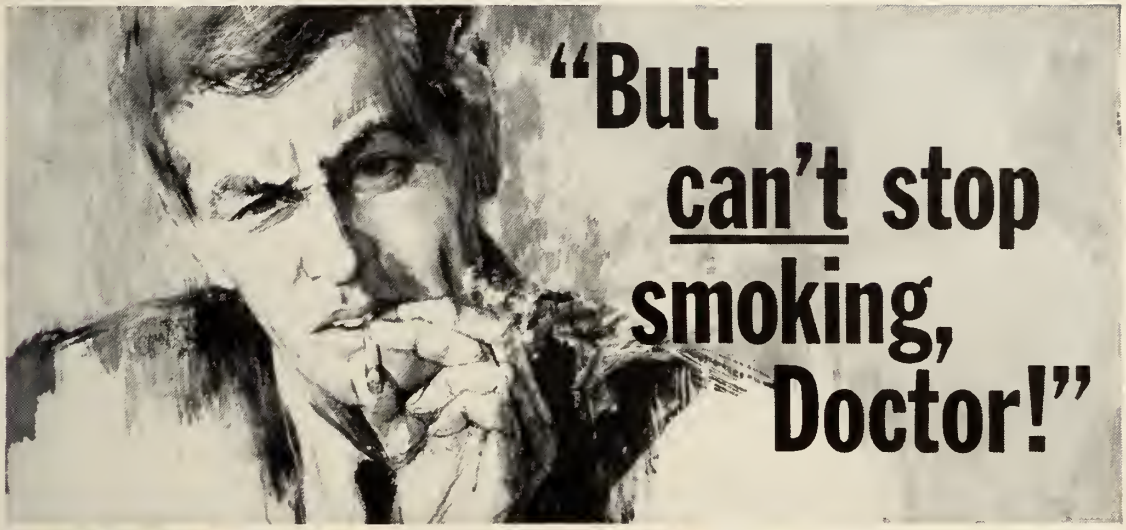
Michigan doctors on the Haven Hill program also included Oscar Stryker, M.D., health director of Macomb County, and Paul T. Chapman, M.D., tuberculosis controller for the City of Detroit.

Detroit AUA Holds Sarnia Meeting; Next at Eloise

The program for the Detroit Branch of the American Urological Association recently at Sarnia featured addresses by doctors from Ontario, New York and Michigan. The only Michigan speaker was R. S.

(Continued on Page 62)

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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, Macmillan, 1960, Ed. 2, pp. 620-622; 2. Edmunds, C. W.: J. Pharmacol. and Exper. Therap., 1:27, 1909; 3. Hazard, R. and Savini, E. Gand., 92:471, 1963. 4. Dorsey, J. L.: Ann. Int. Med., 10:628, 1936; 5. Rasmussen, K. B.: Ugeskr.laeger, 118:222, 1956; 6. Ejrup, B.: Sven. lak. Tid., 53:2634, 1956; 7. Jochum, K. and Jost, F.: Munch. med. Wchnschr., 103:618, 1961; 8. Jost, F. and Jochum, K.: Med. Klin., 54:1049, 1959; 9. Smoking and Health, Summary and Report of the Royal College of Physicians of London on Smoking. New York, Pitman, 1962.

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Detroit AUA Holds Sarnia Meeting; Next at Eloise

(Continued from Page 60)

Bailey, M.D., Port Huron, who discussed "Retroperitoneal Fibrosis."

The Detroit Branch reports the January 22 meeting at Eloise has been planned by Jack Lapides, M.D., Ann Arbor, and Harry E. Lichtwardt, M.D., Birmingham. The next meeting will be April 1 at Ann Arbor.

Exhibit Work by Thom At Oakland University

The entire 44 painting series of "History of Medicine" painted by Robert Thom and commissioned by Parke Davis will be exhibited for its first showing in the home area of the artist this month at Oakland University. The show began January 13 and will close January 27. The Oakland County Medical Society is co-sponsoring this with the Division of Continuing Education at Oakland University.

A special dinner was held January 15 with Bud Guest of WJR as the speaker.

Open Psychoanalytic Session

The Detroit Psychoanalytic Society will hold an open scientific meeting at 8 p.m., January 20 at the McGregor Memorial Building on the Wayne State University campus. The program on "Some Misuses and Abuses of Our Private Language" will be given by Jean Rosenbaum, M.D., Detroit. Martin Schaeffer, M.D., and Edward Fine, M.D., will discuss the paper.

Women's Fraternity Continues

Although its national organization has gone out of existence, The University of Michigan chapter of Alpha Epsilon Iota, national women's medical fraternity, will continue operation as a local group. The national organization was founded in Ann Arbor in 1890.

Pearl Compaan, senior U-M medical student from Holland, Michigan, is president of the chapter.

Flint Physician to Lead Orthopaedic Society

The new president of the Michigan Orthopaedic Society is Hira E. Branch, M.D., of Flint. Elected at the annual meeting in Grand Rapids as president-elect

(Continued on Page 64)

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Flint Physician to Lead Orthopaedic Society

(Continued from Page 62)

was Curtis M. Hanson, M.D., Kalamazoo. Re-elected secretary-treasurer was Richard W. Pomeroy, M.D., Lansing. The annual meeting heard an address about epiphyseal disorders by Robert Salter, M.D., Toronto.

Gives Weller Lecture

W. Stanley Hartroft, M.D., Toronto, presented the Weller Lecture to members of the Michigan Pathological Society in Ann Arbor in December. His topic was "The Juxta-Glomerular Apparatus."

This was the eighth annual Carl V. Weller Lecture sponsored by the Michigan Pathological Society in honor of the late Doctor Weller, formerly professor of pathology at the University of Michigan.

A business meeting of the society preceded the lecture.

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Brief and to the Point

NATIONAL PRESIDENT—Reed O. Dingman, M.D., Ann Arbor, is the new President of the American Society of Plastic and Reconstructive Surgeons. He was elected at the Third International Congress of Plastic Surgery held in Washington, D. C. This 700-member Society is made up of Americans and Canadians who are Board certified in Plastic Surgery.

RE-ELECTED—Lynn A. Ferguson, M. D., Grand Rapids, recently was re-elected as an officer of the American College of Gastroenterology at the annual meeting in Washington, D. C. Doctor Ferguson will continue to serve the national group as secretary-general.

CITED—Hira E. Branch, M.D., Flint, recently received a certificate of appreciation from CARE for his service last year in Saigon with "Medico," a program of CARE. He served as a volunteer in Saigon hospitals, helping Vietnamese doctors with an overload of orthopedic cases.

RECEIVES AWARD—A Wayne State University medical student, Tolbert Small, of Detroit, has received a National Medical-Sloan Foundation Scholarship for four years as one of forty students studying medicine. The program, financed by the Alfred P. Sloan Foundation, is designed to help relieve the shortage of Negro physicians and surgeons.

SPEAKER—James W. Rae, M.D., Ann Arbor, was one of the speakers at the annual meeting of the Michigan Rehabilitation Association.

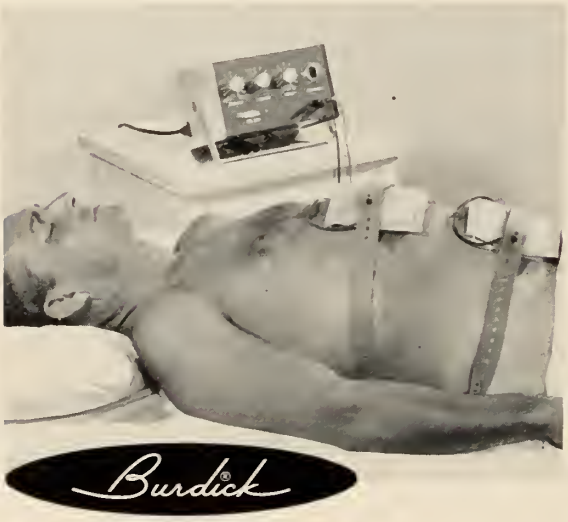
DIRECTED MEETING—James T. Howell, M.D., Detroit, was in charge of local arrangements for the Sectional Meeting of the American College of Physicians held in Detroit in November. The three-day session offered internal medicine specialists, general clinical sessions, combined clinical investigations and basic science sessions, panel discussions and symposia.

SPEAKER—Lawrence Koltonow, M.D., Rochester, addressed the Oakland County Nurses Association recently at the Pontiac State Hospital about "New Trends in Psychiatric Nursing."

ADDRESS RSNA—Seven Michigan doctors spoke at the recent annual meeting of the Radiological Society of North America in Chicago. Kenneth D. McGinnis, M.D., and A. Bradley Eisenbrey, M.D., both of Detroit, discussed "Diagnostic Criteria for Distinguishing Cervical Disc Herniation from Spondylosis in the Nerve Compression Syndrome." Robert S. Ormand, M.D., Ellet H. Drake, M.D., and Henry H. Gall, M.D., all of Detroit, discussed "Angiographic Study of the Left Atrium in Mitral Stenosis." James H. Lofstrom, M.D., and Melvin R. Sikov, M.D., both of Detroit, spoke about



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GUEST SPEAKER—Ralph S. Green, M.D., Rochester, was guest speaker at the Detroit Philosophical Society. He spoke on "The Concept of Reality—An Approach to Its Meaning."

CONFER—Physicians and medical personnel from Chrysler Corporation plants throughout the nation recently held a two-day meeting at Highland Park general offices with Marion W. Jocz, M.D., corporate medical director, in charge. The meeting considered advances in occupational health, plant safety and other matters of mutual concern. Alfred Whittaker, M.D., president of the Wayne County Medical Society, and C. P. Anderson, M.D., health commissioner for the City of Detroit, were guests at a dinner at the medical society's headquarters.

RECEIVES AWARD—Nicola Gigante, M.D., Detroit, received the Distinguished Citizen Award at a recent Detroit banquet from the Italian-American Chamber of Commerce. Doctor Gigante has been decorated by the Italian government and has been active in Italian charitable endeavors helping flood relief victims and homeless boys.

CITED AT MIDLAND—Wilbur D. Towsley, M.D., Midland, was cited recently by the Midland County Medical Society for his "40 years of outstanding service to the community." In 1962, the Midland Exchange Club honored Doctor Towsley as the community's outstanding senior citizen.

200 ATTEND CAREER DAY—About 200 undergraduate students from 22 colleges attended the fourth annual Medical Career Day Conference of the University of Michigan Medical School. Fred J. Hodges, M.D., Ann Arbor, gave an address on "Medicine as a Career."

HONORED BY UNIVERSITY—Joseph C. Foust, M.D., formerly of Ionia, received a special honor citation from his alma mater, St. Louis University "in recognition of outstanding personal and professional accomplishments." He left his Ionia practice in 1959 to become a medical missionary at Tanganyika, where he established a 45-bed hospital.

CLINIC DAY—Providence Hospital, Detroit, presented its annual Clinic Day program on November 6 with speakers covering a variety of topics. Ralph M. Burke, M.D., Chief of Staff, opened the day's program.

PLAN THYROID WORKSHOP—The Thyroid Group at Wayne State University College of Medicine announces that the Third Annual Thyroid Workshop will be held at Woman's Hospital, Detroit, Saturday, February 22. The general subject will be "Thyroid Cancer" and the featured speakers will be Norman J. Nadler, M.D., McGill University,

Say you saw it in the Journal of the Michigan State Medical Society

and Theodore Winship, M.D., Washington Hospital Center. Registration material may be obtained from Robert E. Mack, M.D., Woman's Hospital, 432 E. Hancock, Detroit 1.

COOK LECTURES—Lester J. Evans, M.D., executive associate for Medical Affairs of the Commonwealth Fund, presented the William W. Cook Lectures at the University of Michigan in November. His topic was "The University and Medicine."

RECOGNIZED—Albert E. Heustis, M.D., state health commissioner, received the 1963 McCormack Award given annually to a state health officer for major accomplishments. The award was given at the annual meeting in Washington, D. C., of the Association of State and Territorial Health Officers.

NAMED—Lilliam L. Imperi, M.D., has been appointed as a member of the active medical staff of The Haven Hospital & Psychiatric Center at Rochester.

SPEAKER—"New Approaches in Cancer Chemotherapy Research" was the topic of Charles G. Smith, Ph.D., manager of biochemistry for the Upjohn Company, Kalamazoo, when he addressed the annual dinner meeting of the Michigan Cancer Foundation, December 9. The dinner was held at the Wayne County Medical Society Building.

ACADEMY ELECTS OFFICERS—Fred G. Brace, M.D., Grand Rapids, was named president-elect of the Michigan Academy of General Practice at its annual business meeting in Detroit. He will take office in 1964 succeeding Lyle Korum, M.D., Detroit, president this year. Howard Robinson, M.D., Detroit, was named to succeed Doctor Brace as treasurer, and E. Clarkson Long, M.D., Detroit, was re-elected secretary.

Michigan Authors

A. C. CURTIS, M.D., Ann Arbor, "National Survey of Venereal Disease Treatment," *Journal of the American Medical Association,* October 5, 1963.

A. H. HIRSCHFELD, M.D., and **R. C. BEHAN, M.D.,** Detroit, "The Accident Process (Part II)" *Journal of the American Medical Association,* October 19, 1963.

R. C. Gause, M.D., G. N. Loomus, M.D., Arnold Nedelman, B.S., and **G. O. Clifford, M.D.,** Detroit, "Atypical Sickle Cell Anemia," *Journal of the American Medical Association,* November 16, 1963.

Andrew F. Caughey, Jr., M.D., and **Lawrence H. Krohn, M.S., M.D.,** Detroit, "Variation in the Fetal Electrocardiogram with Period of Gestation," *American Journal of Obstetrics and Gynecology,* October 15, 1963.

I. J. Schatz, M.D., Stephen Podolsky, M.D., and **Boy Frame, M.D.,** Detroit, "Idiopathic Orthostatic Hypotension," *Journal of the American Medical Association,* November 9, 1963.

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IN MEMORIAM

JOHN C. BACKE, M.D., 60, former assistant medical director at the Michigan State Tuberculosis Sanitarium at Gaylord, died November 18, 1963, at St. Petersburg, Florida.

Doctor Backe was born in Montana and was a veteran of World War II. He left the Gaylord position in 1957 due to ill health and moved to Florida. He was a member of MSMS and AMA.

DANIEL BUDSON, M.D., 59, Detroit pediatrician for many years, died November 19, 1963.

A 1927 graduate of the University of Michigan Medical School, he was an instructor in pediatrics there for five years. From 1929 to 1930 he was an exchange resident doctor at Harold Hospital in Paris, before beginning his practice in Detroit. He was a member of the American Academy of Pediatrics, Phi Lambda Kappa medical fraternity, and Maimonides Medical Society, and was on the staffs of Children's, Sinai, Harper and Women's Hospitals.

THOMAS F. BERBEROVICH, M.D., 69, Saginaw surgeon, died November 2, 1963.

A 1916 graduate of the University of Louisville medical school, Doctor Berberovich began practice in Saginaw in 1919 following military service in World War I.

He was a former chief of staff at St. Mary's Hospital and on the staffs of Saginaw General and St. Luke's Hospitals.

SOL G. COHAN, M.D., 71, Muskegon physician for more than 40 years, died November 22, 1963.

A graduate of Chicago College of Medicine, now affiliated with Loyola University, Doctor Cohan began practice in Muskegon in 1918.

He was a Life Member of the Michigan State Medical Society.

MILTON M. FREEDMAN, M.D., 63, Detroit physician, died October 18, 1963.

A graduate of the Detroit College of Medicine, Doctor Freedman had been a city physician for 30 years and medical director of the DSR for the last 20 years. He was a member of the Maimonides Medical Society.

FRANK J. GUGINO, M.D., 58, Reese, died November 19, 1963.

Doctor Gugino graduated from the University of Western Ontario Medical School in 1933, and began practice in Reese in 1934. He was on the senior staff at St. Mary's and St. Luke's Hospitals in Saginaw and General Hospital in Bay City.

ROBERT B. HAUSS, M.D., 69, Detroit physician and surgeon since 1927, died October 14, 1963.

A graduate of Indiana University's medical school, Doctor Hauss did postgraduate work at the University of Pennsylvania before coming to Detroit.

Doctor Hauss was on the staff of East Side General Hospital. He was a member of Alpha Tau Omega and Pi Beta Pi fraternities.

HERMAN A. MEINKE, M.D., 68, Hazel Park physician since 1923, died October 24, 1963.

Doctor Meinke graduated from the Detroit College of Medicine and Surgery in 1920. Following his graduation, he operated the Meinke Research Laboratories in Detroit before moving to Hazel Park in 1923. He was the founder of Helene Meinke Hospital in Hazel Park in 1926.

He was a former member of the Hazel Park school board and a former state president of the Exchange Club.

CHARLES W. PEABODY, M.D., 72, retired former chief of Orthopedics at Detroit's Henry Ford and Harper Hospitals, died November 6, 1963.

A graduate of Harvard Medical School, Doctor Peabody served as head of orthopedics at Ford Hospital from 1922-29, joining the staff at Harper Hospital in 1929 and becoming chief of orthopedics there in 1952. In 1957 he was named senior surgeon on the consulting staff at Harper. He was also on the staffs of Woman's and Children's Hospital, and was chief of staff at the Detroit Orthopedic Clinic and chief of surgery at Sigma Gamma Clinic. He retired in 1958.

He was a past secretary of the American Orthopedic Society; other memberships included the American Society of Orthopedic Surgery, Clinical Orthopedic Society of the Central States, Central Surgical Society, Michigan Orthopedic Society and the Detroit Orthopedic Club.

He was a Retired Member of the Michigan State Medical Society.

JOHN A. SHELDON, M.D., 83, Detroit physician, died October 15, 1963.

A graduate of the Detroit Medical School, Doctor Sheldon was a fellow of the American Geriatrics Society, fellow of the Military Surgeons of the United States, and a Life Member of the Michigan State Medical Society.

CARL F. SHELTON, M.D., 58, Detroit physician for 35 years, died September 29, 1963.

A graduate of Richmond (Va.) Medical College, Doctor Shelton was a major in the Army Medical Corps during World War II. He was former head of obstetrics at Woman's Hospital.

A member of the American College of Surgeons, he also served as president of the Central Society of Obstetrics and Gynecologists in 1958.

AARON V. WENGER, M.D., 86, Grand Rapids physician and surgeon since 1901, died October 24, 1963.

Doctor Wenger graduated from Grand Rapids Medical School in 1901 and took his internship and residency at what is now Blodgett Hospital, followed by postgraduate work at

Johns Hopkins Hospital, Baltimore, and at New York Polyclinic.

Doctor Wenger was a Life Member of the Michigan State Medical Society and a member of its House of Delegates from 1914 to 1954, when he was elected as Honorary Member of the House. He was a charter member of the Kent County Medical Society.

He was on the staffs at Butterworth and Blodgett Hospitals. Memberships included the American and Michigan Societies of Industrial Physicians and Surgeons, International Society for Research in Anesthesia, and the American and Michigan State Societies of Anesthesiologists.

For many years he served as a Kent County medical examiner.

EDWARD P. WILBUR, M.D., 89, Kalamazoo physician, died September 28, 1963.

A graduate of the University of Michigan Medical School in 1897, Doctor Wilbur interned two years at the Amsterdam Eye and Ear Hospital in New York before opening his practice in Kalamazoo in 1899. He retired from practice in 1947.

Doctor Wilbur was on the board of trustees of Kalamazoo State Hospital from 1917 to 1922, a member of the State Hospital Commission from 1922 to 1937, chief of staff at Borgess Hospital from 1925 to 1938, and a staff member at Bronson Hospital.

He was a Life Member of the Michigan State Medical Society.

Letters to the Editor

Dr. Orlen J. Johnson, President
Michigan State Medical Society
Dear Dr. Johnson:

It is a genuine pleasure for me to forward a copy of a resolution relative to a member of the Menominee Medical Association, adopted by the Menominee Board of Education.

To have a member of the medical profession so keenly interested in the welfare of the youth, as illustrated by Dr. Brukardt, is most refreshing. I believe that his attitude and actions were indicative of his dedication to the profession, far beyond the normal call of duty.

I wish to commend you and the Association for having among its members, a man of this calibre.

Cordially yours,
ALEX M. NELSON, *Superintendent*
Menominee Public Schools

16 October 1963

RESOLUTION:

Appreciation to Dr. Herman Brukardt

WHEREAS: Dr. Herman Brukardt, Menominee, Michigan, of his own accord and volition gave unselfishly of his time and professional skill during the past 15 years, or more, by making himself present at all home varsity athletic contests, and

WHEREAS: By so doing he contributed immeasurably to the health, safety, and welfare of the participants, the youth of our community, and

WHEREAS: This same unselfish assistance was extended to visitors, and

WHEREAS: This expression of dedicated service to youth has earned for him the respect and admiration of parents, visitors and youth, and

WHEREAS: The gratitude of the parents and youth concerned far exceed the humble but sincere appreciation reflected in this resolution, now therefore,

BE IT RESOLVED: That we, the members of the Board of Education, recognize with humble thanks and with deep appreciation the professional service rendered this community by Dr. Brukardt in his concern for our youth, commending his conduct to all members of the medical profession. Further, that this resolution represent our expression of sincere appreciation. Be it further resolved, that this testimony of our esteem for Dr. Herman Brukardt be made a part of the records of this body and that a copy be sent to Dr. Brukardt.

This is to certify that the above resolution is a true copy extracted from the minutes of the Board of Education dated 9 October 1963.

ALEX M. NELSON, *Superintendent*
Menominee Public Schools

•

Dear Editor:

The Michigan State Board of Alcoholism has taken notice of the articles on alcoholism published in the October issue of the *Michigan State Medical Society Journal*. The Board has requested that I convey to you and to the Medical Society its sincere congratulations on this excellent work. The Board feels that this recognition of alcoholism as a legitimate problem of concern to Michigan physicians, combined with the variety and high quality of the articles, will make this issue of considerable value throughout the country. Copies of the publication are being furnished to alcoholism programs throughout the United States and Canada by the State Board of Alcoholism.

We have always believed that major responsibility for alcoholism, like any other disease, rests with the medical profession. We have seen our role as one of striving for an acceptance of alcoholism as a respectable illness rather than as an attempt on the part of the state to provide, as a direct service of government, solutions to this human problem.

We hope that many members of the Medical Society will find in this issue a new incentive to recognize and treat alcoholic patients.

The fact that the State alcoholism program had such a small part in this publication is particularly gratifying. The State Medical Society can be proud to have members capable of writing and editing this type of publication.

Sincerely yours,
RALPH DANIEL
Executive Director
State Board of Alcoholism

November 12, 1963

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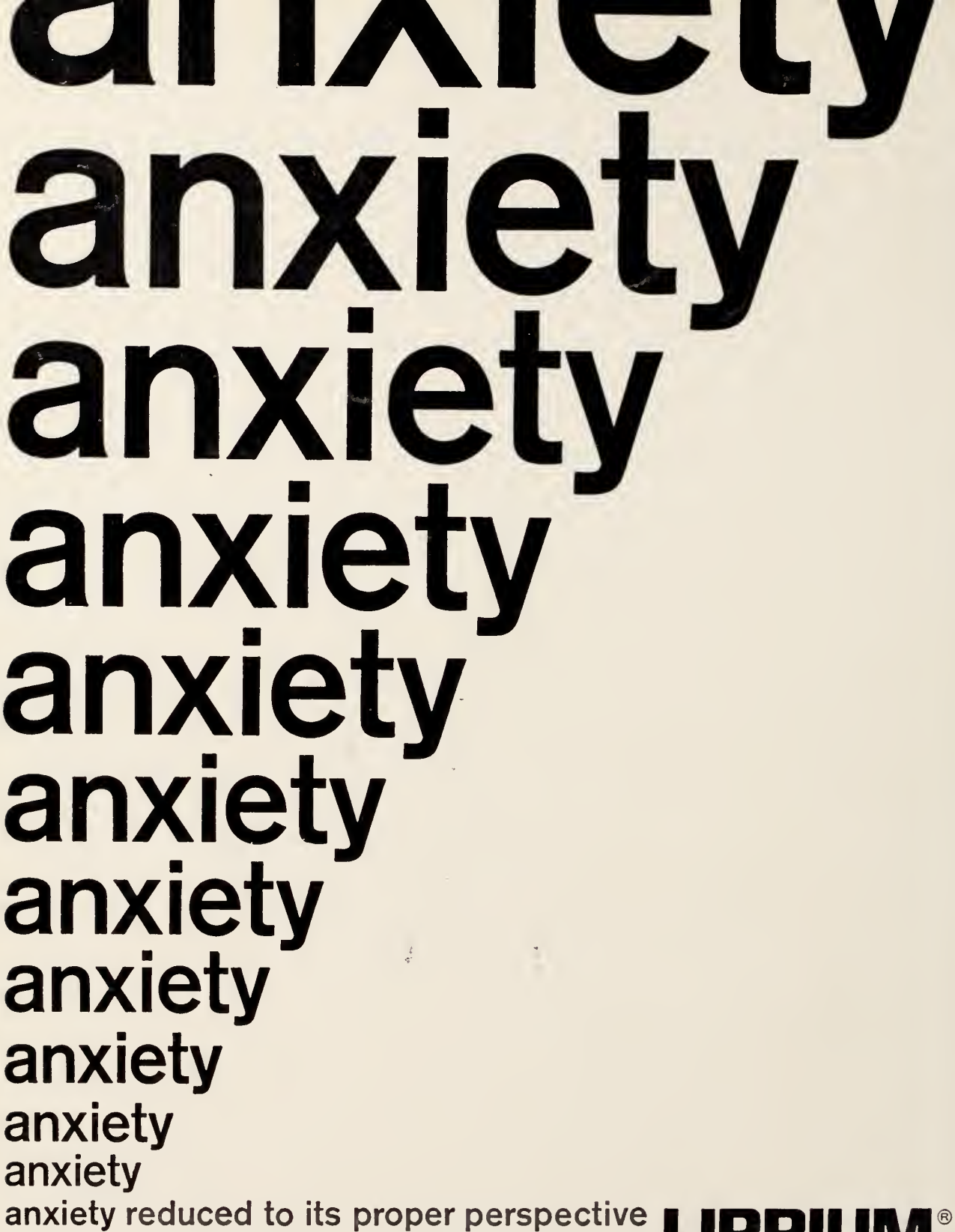
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MICHIGAN
STATE MEDICAL SOCIETY
JANUARY 1964 • VOLUME 63 • NUMBER 1-A

Michigan State Medical Society

Ninety-Eighth Annual Session

September 22-24, 1963

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Digest of Proceedings

of the

House of Delegates

This number is composed of two sections, of which this is Section 2

Michigan State Medical Society
Ninety-Eighth Annual Session
September 22-24, 1963

DIGEST OF PROCEEDINGS

1963 Digest Simplified for Quicker Reference

For more convenient use of the *Digest of Proceedings*, the following new procedure has been adopted:

Immediately following each report or resolution is first, the action of the reference committee on that report or resolution and then, second, the House action on the report of the reference committee.

1963 House of Delegates Proceedings

Ninety-Eighth Annual Session

Michigan State Medical Society

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Michigan State Medical Society

Ninety-Eighth Annual Session

September 22-24, 1963

CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The Ninety-Eighth Annual Session of the Michigan State Medical Society House of Delegates, held at the Pantlind Hotel, Grand Rapids, Michigan, convened at 8:10 p.m., September 22, 1963, James J. Lightbody, M.D., Speaker of the House of Delegates, presiding.

2. Report of Reference Committee on Credentials

Chairman A. B. Gwinn, M.D., reported: "Mr. Speaker, there are 125 delegates seated. This constitutes a quorum and 50 per cent are not from any one county. We also have three medical students, all from the University of Michigan."

3. Invocation

The Speaker called upon R. R. Cooper, M.D., to give the invocation.

4. Speaker's Remarks—J. J. Lightbody, M.D.

I again welcome you Delegates to the Annual Meeting of the House of Delegates and also offer a special welcome to our friends from the two medical schools in the State—Dean Hubbard of the University of Michigan and Dean Scott of Wayne State University—and also a cordial welcome to the junior and senior medical students of our two schools. The medical students have been assigned to reference committees, but they have the privilege of attending any reference committee meeting.

The remarks of the Speaker will be confined mainly to the primary functions of this House, in an effort to direct the parliamentary mechanics in such a way as to minimize any tendency toward organized confusion.

This year there were six working committees of the House of Delegates, and the names and reports of these committees are in your Handbook. The reports of these committees have been referred to their proper reference committees except the committee which concerned itself with "certificates of commendation" which, as you know, has replaced the previous award of Michigan's Foremost Family Physician.

I have asked Dr. Ralph Cooper, the chairman of this committee, to report directly to the House tomorrow morning so that prompt action may be taken on the recommendations of the committee if the House wishes to do so. This action is necessary so that the men who are to receive the award may be notified in time to be present at one of our meetings on Tuesday.

During the past year there was another poll of the membership on Social Security, and all of you have been informed of the results of this poll; but to refresh your memory, there was only one question asked, and that was: "Do you favor inclusion of physicians under Social Security?" The certified results were as follows: Yes—3,099; No—1,845; No opinion—20, with a total number of replies of 4,964. In a previous poll of the membership in 1959, with only one question involved, there was a total number of replies of only 2,829 and there were 1,781 in favor of Social Security and 1,048 opposed—so that the trend in the State of Michigan seems to be favoring Social Security.

This year, in addition to the routine business of the House, we will have the privilege of hearing Governor George Romney, who is scheduled to appear before the House at 11 a.m. tomorrow morning. This will be an open meeting, and all friends of the Michigan State Medical Society are invited.

For the past two years we have tried to have as many resolutions as possible sent in before the House meets so that they can be printed and given to you before the first meeting of the House. Each resolution will be numbered, and when resolutions are called for tomorrow morning we will begin with No. 1 and the introducer of the resolution will read only the "Resolved" portion of the resolution. Any resolution which has not been printed previously will have to be read *in toto* to the House and three printed copies of the resolution submitted to the Secretary at the time the resolution is introduced.

The order of business of the House as printed in the Handbook shall be the official order of business, but this may be varied by the Speaker, at his discretion, subject to objection sustained by the House. The Speaker may grant the privilege of the floor to such persons as may be presented by the President of this Society or the Chairman of The Council or others who may expedite the business of the House, subject to objection sustained by the House.

Your Speaker and Vice Speaker will attempt to direct the business of this House in an efficient manner to your satisfaction in accordance with proper parliamentary procedure, and we plead for your continued cooperation and patience.

The Reference Committee on Reports of Officers, W. C. Beets, M.D., Chairman, commended Speaker J. J. Lightbody, M.D., for his ability to impart words of wisdom in a brief, concise and efficient manner.

The House adopted the report of the Reference Committee.

5. President's Address—C. I. Owen, M.D.

At this time, when the President is privileged to report to the House of Delegates, I thank each and every one of you, as well as other MSMS members who have cooperated to make this year go smoothly. Especially, I thank those of you who were

so hospitable when I visited county societies and other medical groups throughout the State. On these visits I found a spirit of cooperation at all levels, evidence of high scientific and professional standards, and considerable activity among our members in community affairs and service.

My sincere thanks go to Mr. William J. Burns and his efficient staff. Bill, of course, is everywhere at all times, and is on top of every problem and detail. Hugh Brenneman, Warren Tryloff, Mike Riley, Ralph Wills, Herb Auer and Bob Roney contribute much to our Society and its activities and program as real professional career men in medical society administration. All have been greatly helpful to me during my term of office. Ray Scott and Dick Campau have been easily available to me in my home town at the Detroit office with their efficient secretaries. They were especially helpful in many details and in taking care of much of my correspondence.

The various State Society committee chairmen and members deserve special mention. I wish there were time to detail the work that many of them have done. No one can ever know the hours and days spent, the preparation involved, and the valuable experience that many of our members generously contribute to Society work. Thanks to all of them.

Honorable mention must go to our Woman's Auxiliary, under the able leadership of Mrs. Ross Taylor during this past year. The activities, the service work and the availability for special assignments, make this organization of unique value and a real adjunct to some of our Society activities. Congratulations, ladies! We couldn't do without you. You really make our existence worth while.

During this past year, a number of important and serious problems have been solved and progress has been made toward the solution of others. These activities are recorded in our committee reports and in the proceedings of The Council. Some problems remain unsolved but in due course of time these, too, will be solved through study and careful consideration.

Any attempt to chronicle at this time the activities of the President during this past year would be too time consuming. It is sufficient to say that being President has been an interesting and educational experience. It has demonstrated to me more than ever that the medical profession in Michigan is made up of sincere, hard-working doctors of medicine practicing top-quality scientific medicine and upholding high professional standards. What more need be said! I am proud indeed of our profession and its members, and am proud to have served as its President.

The Reference Committee on Reports of Officers, W. C. Beets, M.D., Chairman, presented the following report:

"Our President, Dr. C. I. Owen, has, in his message, demonstrated his administrative ability. We admire the modesty and brevity of his report, which conceals the fact that in the discharge of his duties he has traveled thousands of miles and given countless hours of time.

"The Committee has looked beyond the content of his report and wishes to recommend that the House of Delegates take due cognizance of the daily dedication of Dr. Owen during his term of office."

The House adopted the report of the Reference Committee.

6. President-Elect's Address—Orlen J. Johnson, M.D.

For over 30 years, I have been in organized medicine merely attempting to discharge the responsibilities I have been given, without thought to where it would lead me. That I am in this position fills me with humility, pride, appreciation and apprehension of the year ahead, lest I not represent you and all the members of this good Medical Society as some ninety men have before me.

It has been my lot to visit and to meet with medical groups in 48 states, and for a few years to take part in the activities of the AMA House of Delegates; but more important are the associations and deliberations I have had with members and groups, medical and otherwise, in Michigan. The past year has been full, an apprenticeship, and I am prepared to go at an even faster pace in the coming year to do a job which will be a credit to the Michigan State Medical Society.

In the deliberations this week, with your usual sober thought and consideration and respect for the rights and opinions of others, we can make profitable decisions for greater accomplishments of the Michigan State Medical Society.

President Owen's year has been one of which he and you can claim valuable accomplishments. It was a lively year. Committee activity was gratifying. It isn't fair to single out any one or few, but the Program Committee has arranged outstanding scientific sessions this week; the Mental Health Committee has had an active, successful year; the Legal Affairs Committee each year is one of the most active. This year was an exceptionally productive one for this Committee, with several of the measures recommended by this House being enacted. A good working relationship with the State Administration has been and will continue to be maintained.

The establishment of a Committee on Medicine and Religion in the Michigan State Medical Society this year, under the aegis of the American Medical Association, will return great credit to medicine.

The Committee on Iodized Salt reports that there is a significant increase in the incidence of endemic goiter. They have recommended a program which will be helped materially with all physicians recommending the use of iodized salt.

Another accomplishment of President Owen is arranging to have Dr. Edward R. Annis, President of the American Medical Association, speak Thursday night.

The Department of Socio-Economics, instituted by vote of this House two years ago, has far exceeded the most optimistic expectations. The research and material from this Department have provided invaluable factual data in several fields of activity. To it in part goes considerable credit as well as to other members of the headquarters staff for this portion of the Governor's letter bearing on changes in Medical Aid to the Aged (Kerr-Mills):

> I have appreciated the manner in which the State Medical Society has presented their viewpoint, and also appreciate the consideration shown throughout their combined exploration of this most important issue.
>
> Cordially yours,
> George Romney

Many years of association with the activities of the Michigan State Medical Society have been indelibly stamped with the value, leadership and loyalty of Bill Burns. Without fear of repetition or exaggeration, an important part of the growth and attainments of this organization are intricately interwoven with his activity and ability.

Unfortunately, I shall have his advice and counsel for only a few months. However, the know-how, sincerity and loyalty of the staff he has assembled will enable the organization to proceed with unmatched energy and direction in the interest of the people of our State and the Michigan State Medical Society.

I am going to discuss a few of the matters that need consideration by this body.

The Community Mental Health Act, passed by the Michigan Legislature this year, calls for definite activity and leadership by local medical societies. The fact that this important program will be four to five years in development doesn't mean medicine can lag behind in the organization of community programs.

The profession has always supported high standards of medical education and the expansion of facilities to meet the needs of the population. The committee for planning higher education in Michigan recommended completion of the plans at the University of Michigan Medical School, enlargement of the facilities of Wayne State University Medical School to their maximum, a two-year program in human biology at Michigan State University and concurrently, with the terminal phase of these programs, the establishment of a third medical school in Michigan.

The Michigan State Medical Society has officially endorsed and supported this planning, which will maintain the necessary high standards of medical education and meet the needs of the State. We should publicly and emphatically reaffirm our active support of this plan. We should view with extreme alarm and vigorously oppose any plan of healing arts education which lacks the scientific quality to which the people of Michigan are entitled.

The drive for Medicare will take place before the elections

next year. "Operation Home Town" for county medical societies has been prepared by the American Medical Association to combat the political propaganda. This is a necessary stopgap, but the program of the Michigan Medical Minute Men and AMPAC is one which will give us long-term support by the election of legislators and congressmen favoring our philosophy of free enterprise.

AMPAC was successful in 70 per cent of their election campaigns last year. AMPAC spent more money in Michigan in past elections than we contributed to it. It is imperative out of self-respect that the doctors of Michigan should do their part.

Michigan Medical Service long has been the vortex of activity in the deliberations of this House and throughout the State between sessions. In light of events in this area since our last meeting, I shall impart to you some impressions before pertinent matters are decided involving the medical profession and the Michigan State Medical Society.

I have given unqualified support to Michigan Medical Service since its inception. I am impressed with the zeal and sincere efforts of the medical members of its Board of Directors to carry out its successful operation under adverse circumstances. They are your elected representatives.

I am aware of the powerful outside forces which are attempting to discredit the medical profession with half truths and subterfuge through Michigan Medical Service and to use Blue Shield in their program to control medicine. This power play was not always evident but it is now out in the open, at least to us.

There can be no question that Blue Shield plans have taken the lead and been the force whereby a huge segment of the population—over 90 million—protect themselves with private prepaid medical care insurance. This also has been a potent factor in resisting the drive of selfish politicians to saddle the American public with government medicine or Fabian socialism from which there is no relief or escape.

Why repeat these facts you all know? Many times I have heard individuals say they do not have a crystal ball to tell what will happen if we do so-and-so, but as medical practitioners you make decisions equating past experience with current factors, and arrive at a prognosis.

What is our past experience? Since 1940 there have been critical decisions by Michigan Medical Service revolving around fiscal solvency and medical philosophies. The most critical point was reached on May 22, 1963, when a consent decree was entered into for economic survival. In the midst of this furor the medical profession was falsely blamed for the rising costs of medical care, without mention of the concomitant increases in value received. These are the techniques of those who would control medical practice.

The consent decree is a contract binding Michigan Medical Service to controls not heretofore exercised by the Michigan Department of Insurance. It places a large segment of the practice of medicine in Michigan under the strong influence of a State agency. The crystal ball of experience shows the road down which we are heading. With the expectation of contradiction and contention I am ready to defend this premise.

The Board of Blue Shield is an autonomous body charged with the operation of the corporation. The corporate body or House of Delegates has limited legal functions. They alone can change or amend the Articles of Incorporation. This well-intentioned plan to provide service benefits has become the instrument through which medicine may be controlled in the future.

I stated my unqualified support of Michigan Medical Service and regard for the members of the Board. They have acted within their rights for the sole purpose of keeping the corporation solvent. I advocate no action here against Blue Shield or members of the Board.

However, if the medical profession is to continue fighting government control and expects the continued valuable support of its friends, we have the responsibility of resisting the dictates of outside control. Now the corporate body can, without prejudice or jeopardy, take action which is consistent with our fight, by refusing to accede to further pressure which survival may force the Blue Shield Board to accept. The necessity of rejection of dictation transcends any other course.

In the next 48 hours, you will have the opportunity to take action which will show our sincerity of intent to support free enterprise—to give not just lip service but action that will give meaning to our fight of the past and in the future for the American freedom to practice the medicine that is still the best in the world.

My high regard from many years of association with this body tells me your decisions will not deviate from the high principles you have always maintained in your deliberations.

The Reference Committee on Reports of Officers, W. C. Beets, M.D., Chairman, presented the following report:

"The speech of our President-Elect, Dr. Orlen J. Johnson, reveals a keen awareness of the problems facing medicine today. We are confident that he will valiantly fight to protect freedom in the practice of medicine.

"We look with favor on the formation of a committee to study the relationship of religion and medical practice.

"We share his enthusiasm about the work of the Socio-Economic Committee. We endorse his vigorous stand on the maintenance of high standards in medical education.

"In reference to his attitude toward Blue Shield, this Reference Committee feels that his views are controversial but that they are expressed in a forthright manner. The problems raised by Dr. Johnson are being considered by other committees, and it is our hope that a satisfactory solution will be forthcoming."

An amending motion was adopted "that special commendation be given to Dr. Johnson for his suggestions, and hope that the House of Delegates will proceed to further the ends he has asked for."

The House adopted this report of the Reference Committee, as amended.

7. Report of Michigan Delegates to American Medical Association—Chairman Wm. A. Hyland, M.D., Grand Rapids

Under Officers' Reports you will find a résumé of the American Medical Association meeting in Atlantic City on June 16-20 last. This includes the transactions of the House of Delegates, also excerpts from the scientific papers and exhibits. You will also find a rundown of the more important phases of the meeting in the August 1963 edition of the Michigan State Medical Society Journal, beginning on page 825. A report of the meeting in Los Angeles last November-December was published in the March 1963 issue of the State Medical Society Journal.

As this evening's program is rather long and you will be starting early tomorrow morning, I will briefly relate some of the more important matters, but urge you to read (if you have not) both the scientific portion as well as the portion dealing with actions of the House of Delegates in the Handbook.

The announcement of the Board of Trustees of the American Medical Association of the establishment of a new Institute for Biomedical Research, under the direction of the more well-known research men in the various phases of biological sciences, to study events that take place within the cell, was very special news. This will be purely on the scientific aspect, with no medical service to patients and no graduate training leading to a degree. The plan does not include government financing but rather grants from foundations, corporations and individuals.

Among other actions of the House of Delegates were: The enlargement of the Board of Trustees; rearrangement of the Sections and intensifying the scientific programs; compensation of interns and residents; physicians' pension plan; social security for physicians, and a report on the study of tobacco and disease.

The New York resolution for a survey of the members of the American Medical Association regarding their feeling on social security, was defeated.

The Michigan delegates reported the result of the survey on social security, authorized by the Michigan State Medical Society House of Delegates in September 1962 of the State Medical Society membership, to the Executive Vice President and the Speaker of the AMA House of Delegates, as requested by the resolution and signed by the Chairman of the Michigan State Medical Society Council, its Speaker, its President and

the Chairman of the Michigan Delegates to the American Medical Association. In addition, the Chairman of the Delegates reported it to most of the chairmen of the other state delegations attending the American Medical Association in person.

The Michigan delegates, as a result of the State poll, all voted for the New York resolution in favor of a poll on social security of the AMA members. Some felt, as organized medicine is opposing social security aid in medical care for a segment of the population, as advocated by President Kennedy, that we might be in a paradoxical position by urging it for physicians.

There were seventy-one resolutions presented, several covering the same subject. When they were catalogued the result was about half as many.

Our advisers in Congress in Washington—Congressmen Mills and Durwood Hall, the latter a member of the AMA House of Delegates, requested rather restricted advocating of some of the Medicare resolutions, and advised the Legislative Committee of the American Medical Association to withhold all except only the broadest resolutions on this subject at the time. As the American Medical Association must depend on these sources for advice, the executive office requested the House to bear with them on this subject for the time being. However, your Delegates await your advice on these matters.

More pay for interns and residents, which report was sent to the House last November, again came before the House in a more acceptable form. Many of the members most interested in this subject contacted the Medical Education and Hospitals Council during the intervening six months, which resulted in a report much more favorable to all concerned in June.

I wish to thank all of the delegates to the AMA for their gracious advice and help at all times.

The Reference Committee on Reports of Officers, W. C. Beets, M.D., Chairman, presented the following report:

"Your Reference Committee feels that the Michigan State Medical Society has had excellent representation at the American Medical Association Session.

"We appreciate the concise report of the policy-making branch of our Society. We also like the splendid report on the scientific aspects of the June 1963 meeting of the American Medical Association. We urge the membership of the Michigan State Medical Society to read and study the complete report.

"We pay tribute to our delegates for the time and effort expended in our interest. It is the feeling of the Reference Committee that the delegates acted in our best interest, guided by the knowledge and experience of the medical and political talents of the American Medical Association."

The House adopted this report of the Reference Committee.

8. Report of Woman's Auxiliary to Michigan State Medical Society—Mrs. Ross V. Taylor, President, Jackson

It is a pleasure to bring you greetings from the woman's auxiliaries and to report on our activities during the past year.

We launched our year's work in October with our district meetings. The State committee chairmen as well as the State officers traveled around the State to these meetings. Every effort was made to inspire the local auxiliary officers and members, and to promote Auxiliary projects and programs.

In March, we held our Midyear Board Meeting in Detroit. This meeting was attended by the county presidents and presidents-elect, as well as the State officers and chairmen. We had as our guest speaker Mrs. Frank Gastineau, the only woman member of the Board of the American Medical Political Action Committee. At this meeting a resolution was passed offering the Auxiliary's aid to the State Medical Society in "Political Action Committee" activities.

In the field of legislation, "Operation Home Town" was launched in Michigan the first of May.

During the past year we have contributed $16,559.40 to the American Medical Association Education and Research Foundation. This is an increase of $5,076.38 over the preceding year. Macomb County received a National County Achievement Award based on size of membership and contribution. They contributed $1,679.02 with seventy-three members. Michigan was fifth of the fifty states in total contributions by the auxiliaries. Following are the contributions by county auxiliaries. Any money received after June 1 will be listed with next year's totals.

Allegan		$ 25.00
Bay		1,094.37
Berrien		399.22
Calhoun		902.56
Clinton		10.00
Delta-Schoolcraft		25.00
Eaton		125.00
Genesee		976.00
Gogebic		22.00
Grand Traverse-Leelanau-Benzie		246.87
Huron		142.00
Ingham		1,000.00
Ionia-Montcalm		5.00
Jackson		265.00
Kalamazoo		100.00
Kent		565.00
Lenawee		20.00
Livingston		25.00
Macomb		1,679.02
Marquette-Alger		671.50
Mason		75.00
Menominee		25.00
Midland		402.50
Monroe		55.00
Muskegon		1,642.91
Newaygo		60.00
Oakland		452.00
Saginaw		1,793.00
Sanilac		111.00
St. Clair		737.10
St. Joseph		25.00
Tuscola		20.00
Washtenaw		457.00
Wayne		589.33
Wayne—Southern Branch		1,016.50
		15,759.88
State Auxiliary	$500.00	
State Convention Project	200.00	
District Meetings	65.52	
Midyear Board Meeting	34.00	799.52
1962-1963 Grand Total		$16,559.40

"Medical Self Help" has been promoted. The outstanding Civil Defense program was presented in Detroit for 200 presidents and presidents-elect of women's clubs in the city. An original play, "Minutes or Eternity," was presented by the Wayne County Auxiliary. It was written and directed by one of the members, Mrs. Earl Weston. The play was approved by the Civil Defense office before presentation and was very well received. This play, with cast and director, is available to the county auxiliaries in the State.

Special work was done in Oakland County in cooperation with a PTA in an underprivileged area. Clothing and toys were collected and distributed. Auxiliary members also taught adult education courses.

The Ingham County Auxiliary works with the Mobile X-Ray Unit in distressed areas. Members make a door-to-door canvass and offer immediate transportation to the mobile unit or offer to return again during the two-day period the unit is in the area and provide transportation at a more convenient time. The Kent County Auxiliary assisted their medical society with their most successful Health Fair.

International Health Activities, our newest project, has been well received. Large donations have been sent to World Medical Relief in Detroit. We were privileged to have its director, Mrs. Auberlin, speak to us at one of our State meetings.

In the field of Mental Health, much progress has been made in the preventive field by promoting the use of "Milestones to Maturity." Several loads of sample drugs were collected and taken to our State mental hospitals. Favorable legislation was promoted.

Recruitment for Health Careers has continued as one of our major projects. Our component auxiliaries have scholarships and loans. We have assisted with and sponsored career days and career clubs.

Over 3,000 high school students in the State participated in our TB and Respiratory Disease Speaking Project. They wrote and spoke not only about TB but also about the dangers of

smoking. This is a very important health education project, and we hope to expand it during the coming year.

"Today's Health" is continued as a project by many auxiliaries. It is placed in school libraries and public places at Auxiliary expense.

The State Auxiliary contributed $100 to the Michigan Health Council, and $300 to the Woman's Auxiliary to the Student AMA. We added a third Student Auxiliary Chapter in Michigan last year, in Oakland County, for the wives of interns and residents.

These things, and many more, we have accomplished with a membership of only half our potential. A year ago the State Auxiliary President, Mrs. Owen, urged you to go home and ask your wives if they were members and, if not, why not. We have not, however, had an increase in our membership during the past year.

You—most of you—have acknowledged us as your allies. I wonder if you are fully aware of your "woman-power potential." Are you in your counties taking time to give your wives in their auxiliaries the guidance they need? What we accomplish for American medicine, for you—and this is our sole reason for existing as an Auxiliary—can be done only by the county members who are your wives.

Are your auxiliaries working on projects that you, their medical societies, endorse? Unless Auxiliary members know what their medical societies want them to do, and what they do not want them to do, they are not in a position to make a maximum contribution to the over-all effort.

I want to thank the Auxiliary officers, chairmen and members for their cooperation and for a job well done. I want also to thank the State Medical Society for financial assistance for our State convention, for assistance in publishing our "Auxilium," and for mimeographing done by the State office staff.

Most of all, I want to thank my husband for his encouragement and for making me a doctor's wife. It has been a privilege to work for American medicine—for my husband—for our three sons—for all of you—and for the future.

The Reference Committee on Reports of Officers, W. C. Beets, M.D., Chairman, presented the following report:

"The Reference Committee thanks Mrs. Ross V. Taylor for the report of her activities as President of the Auxiliary. We recommend to the House that a strong plea be made to members of component societies to encourage membership of their spouses in this organization.

"We especially admire the drive which enabled the Auxiliary to increase its contributions to the American Medical Association Education and Research Foundation by 50 per cent over the preceding year.

"The Macomb County Auxiliary is to be especially commended for its excellent accomplishments."

The House adopted this report of the Reference Committee.

9. Report of Michigan State Medical Assistants Society —Mrs. Dorothy Brandis, President-Elect, Lansing

The Sixth Annual Convention of the American Association of Medical Assistants was held in Detroit immediately following the Michigan State Medical Assistants Society Annual Meeting in September 1962. Michigan was represented by four delegates and four alternates. Reta Stahl was elected to the Board of Trustees and Glenn E. Millard, M.D., to the Advisory Committee. Two days preceding the convention, candidates took the pilot study certification examinations for the American Association of Medical Assistants.

An officer workshop was held in Grand Haven in November.

Michigan State Medical Society County Secretaries' Conference was attended by two representatives in January.

The Sixth Annual Seminar in March, in Detroit, attracted 144, representing twenty-one counties, to hear a panel on laboratory procedures and the L. F. Foster Lecture, a speaker about *S. S. Hope.*

The Seventh Annual Meeting of the American Association of Medical Assistants will be held in October in Miami, Florida. Four delegates and two alternates will represent Michigan. Some of our members will participate in the Board Certification examinations to be given for the first time two days prior to this meeting.

The Bulletin has been in trouble; one issue was missed; its staff is in the process of change in format, and we hope the difficulty will soon be overcome.

Three new counties are organizing. The present membership is just under 1,000, with 172 new members.

The educational program continues in six areas. The pilot study program, sponsored by the University of Michigan Extension Service, has been completed.

Civil Defense and Legislation programs continue to be active in support of the medical profession's programs.

We will again honor a medical assistant of the year.

A new member brochure has been written.

The Constitution and Bylaws have been revised and submitted to the MSMS Council.

Following the Annual Meeting in September, the various activities of the Society, committee appointments, program, and so on, did not get under way as expected. Since the resignation of the President in January, the committees are functioning in an attempt to regain lost time.

As of this writing, the request for closer liaison between the Michigan State Medical Society and the Michigan State Medical Assistants Society, including our request for secretarial space at headquarters, has not been acted upon. Such liaison exists in other states, and we would hope for favorable action. A central location has become a necessity for efficient operation.

The Michigan State Medical Assistants Society appreciates the privilege and opportunity of being associated with the Michigan State Medical Society, and will endeavor to make every effort for continued cooperation. We are cognizant of our need for each other. We thank you for the use of facilities for our Board meetings, and we are very grateful for the counsel of Drs. G. E. Millard, R. L. Green, H. C. Tellman and T. J. Trapasso, our Advisory Board.

The Reference Committee on Reports of Officers, W. C. Beets, M.D., Chairman, presented the following report:

"We were very sorry to learn that Miss Esther G. Bartlett, President, was unable to appear in person. The President-Elect, Mrs. Dorothy Brandis, made an excellent impression.

"We note with gratification the continuing growth of this organization.

"We trust The Council will, this year, investigate the possibility of furnishing secretarial space in recognition of the request made in this report."

The House adopted this report of the Reference Committee.

10. Reports of Michigan Medical Service—Sidney Adler, M.D., President, Detroit

I know that many of you have had some questions on the consent judgment, as to how it came about, why it was necessary, and its possible long-range effect on Blue Shield. The question has also been raised as to who is running Blue Shield now.

The Board of Directors of Michigan Medical Service made a judgment on the answer to questions such as these, and many more, and accepted the consent judgment. Written analyses of the consent judgment were sent to every member of this House of Delegates, and we have discussed all questions pertaining to it before The Council of the Michigan State Medical Society, the Councilor Districts and other gatherings of the Michigan profession. It is covered at great length in the Annual Report which is included in your Handbook. I will not, therefore, go into this section of it, since reference committees will take this up and discuss it in the formal course of their business.

Before we go into the Supplemental Report, however, I would like to point out that Blue Shield is a solvent corporation, and I believe a stronger Blue Shield today because of the events and actions which occurred during the past twelve months.

There were two time-consuming situations this past year which required much of our corporate energy:

1. The Senior Citizen contract in the fall of 1962.
2. The rate adjustment in 1963.

In addition to these major issues, Blue Shield has continued work on some of its more basic problems:

1. The steady increase in the rate of frequency of use (utilization) of services.
2. Increasing loss ratios, due to adverse selection.
3. Enrollment problems in the market place.

I shall take up these matters one at a time.

The frequency-of-use rate is one of the basic problems besetting our prepayment plan.

The frequency of services has increased at a rate of 12 per cent last year, with the related cost increase at $6 million. If this were to continue during the next ten years, Blue Shield rates would more than double.

Chances are that we would be out of business and confronted with government-controlled medicine.

Just look at some of the facts. The over-all frequency of services for the last three years has been increasing progressively.

Class I benefits have averaged a 5 to 6 per cent increase.

Surgery has risen 8 per cent; Medical, 4 per cent and Anesthesia 5 per cent.

Class II benefits have averaged a 15 per cent increase, composed mainly of a diagnostic x-ray increase of 12 per cent, radiation therapy 35 per cent, and EKG 18 per cent.

How much of these increases are due to the aging population, or to better quality of care, or to overutilization? These questions must be answered.

FREQUENCY OF SERVICES (UTILIZATION)
PER CENT INCREASE

	1962 over 1961	1961 over 1960	1962 over 1960	Three Year Average
ALL BENEFITS	*12%*	*9%*	*20%*	*11%*
CLASS I	*6%*	*5%*	*10%*	*6%*
Surgery	8	6	13	7
Medical	2	9	9	4
Obstetrics	*(10)	(3)	(15)	(7)
Anesthesia	8	4	10	5
CLASS II	*18%*	*11%*	*28%*	*15%*
Diagnostic x-ray	16	8	23	12
Radiation therapy	23	41	70	35
EKG	19	17	37	18
Pathology	35	26	66	30
Consultation	13	25	40	20
Tech. Surg. Asst.	8	23	27	12

*( ) denotes decrease.

Additional problems arise from the fact that since the inception of the M-75 contract in October of 1958, Plan A cost has risen 60 per cent. Plans B, C and D costs have increased a total of 27 per cent.

We were challenged during the past year because of these rising costs which required new rates.

Michigan Medical Service was on the verge of insolvency and had to take radical steps to save the Plan.

However, Blue Shield will not, cannot, continue to exist under such pressures.

It must work from within to avert the financial crises which have overtaken it at all too frequent intervals in the past.

As subscribers become more knowledgeable of contract benefits and request more elective procedures, the responsibility falls upon the medical profession to make basic determinations of what is medically necessary and what transcends basically good medical care.

The medical profession must recognize once and for all that Blue Shield cannot order, cannot direct, cannot police its parent body.

Are we overemphasizing the gadgets of medicine but failing to bring to patients the good basic knowledge we already have?

The medical profession must decide where to draw the line between necessary use and over-use.

I am talking about the quality of medical care—the difference between good care and over-care.

It is something for the medical profession to give careful study and evaluation.

It is something for the medical profession to direct and control.

It is definitely not a prerogative or a duty of Michigan Medical Service.

Blue Shield can provide the manpower and statistics to point out the variations in medical care, but it should not fix standards of medical practice or procedures.

Make no mistake about it, there are members of the medical profession who would like to make Blue Shield the third party.

The moment the medical profession hands over any of its rightful responsibilities to a non-medical agency, even one of its own creation, the profession is asking for trouble.

The Michigan Relative Value Scale is one of these responsibilities of the medical profession.

We know that the fees in themselves are not the cause for the increase, but rather the frequency of use—which may be good medical care.

Michigan Medical Service has studied the new Michigan Relative Value Scale for a long time.

Michigan Medical Service had a clear directive from the 1962 House of Delegates to put the scale into effect.

The three-part motion of the 1962 House of Delegates concerning the Michigan Relative Value Scale reads:

"(A) Approval of Michigan Relative Value Scale as a basis for negotiating fee schedules with all governmental agencies, with the guideline that the fee schedule for the average income group is to be the basis for such negotiations, *and referral of the RVS to the MMS Board of Trustees for implementation as soon as practicable.*

"(B) Request of MMS that it use the RVS in any and all contracts which MSMS is expected to implement on a service basis.

"(C) Request MMS that it readjust at least every three years the monetary unit value for the Relative Value Scale."

The evaluation of the Scale was based on *not increasing* the liability of the corporation, using the same frequency of service.

Blue Shield did not put the new Scale into effect in 1963, because the benefit-dollar had to be reapportioned to such an extent it would have a significant financial impact in some areas of the medical profession.

The Blue Shield Board of Directors decided, therefore, that the House of Delegates should have another opportunity to consider the consequences of its 1962 motion.

The Board passed the following motion on August 28, 1963:

"Motion was made, seconded and carried to present this material to the 1963 House of Delegates of the Michigan State Medical Society as information as to what would happen if we followed their previous resolution, and request further consideration of the Michigan Relative Value Scale by the Michigan State Medical Society."

You have been given a report of these studies by Michigan Medical Service.

This factor is also adding to our loss ratio.

It is caused by the increased number of aged and infirm in our membership, and the steady inroads into our better-risk groups by commercial carriers.

These causative factors are increasing each month, each year.

In recognition of this problem, the Board of Directors has instructed management to study ways and means to stop this erosive effect.

Merit or experience rating is being studied as a possible solution.

This has meant a review of Blue Shield's rating structure.

The principal aspect of this review is the recognition of individual group experience in the determination of the rate for the particular group.

Progress on this study has been reported to the Board of Directors.

The third and final basic problem for this corporation involves subscriber enrollment and the market.

In this area, the Board of Directors and its enrollment committee have been extremely active.

The Board has instructed management to develop flexibility in its contract offerings.

The rising cost of M-75 has made it apparent that a useful, lower-cost package of benefits must be made available in an increasingly competitive market.

This must be provided on a sound financial basis.

This basic contract is being designed to provide surgical,

obstetrics and anesthesia as fundamentals, with the remaining M-75 benefits (including medical days, x-ray, EKG, laboratory, etc.) obtainable as riders on the basic contract.

This information has also been outlined in reports you have in hand.

These three areas of endeavor have been presented for your information, to let you know what Blue Shield management is working on and the direction it is taking.

They are by no means a summary of its activities.

It is interesting to note that all the outside studies of prepayment made (McNerney, Bowles, etc.) during the past few years have considered the basic issue—cost. Nonetheless, the reasons and solutions for the rising subscription costs were never found.

It is not the science of medical care but the economics of medical care that is bringing us face to face with local, State and Federal Government.

Economics is also bringing us face to face with some of our larger consumer groups.

They are constantly asking how and where their subscription monies are going.

These groups are spending millions of dollars annually and they have a right to know.

Health care, on an organized basis, is gaining greater attention, and these consumer groups are generating tremendous interest in the monetary aspects of health care.

Blue Shield of Michigan has the largest scope of benefits and the largest dollar volume of any plan in the United States.

We are working today not merely to keep its coverage broad, but to keep it alive so that it can continue to serve the people of Michigan.

In order to do this, we must solve our three most basic problems: the increased frequency of use, adverse selection, and enrollment.

Blue Shield cannot do this alone.

It must have the help of the medical profession of the State of Michigan.

The Reference Committee on Medical Service and Prepayment Insurance, James B. Blodgett, M.D., presented the following report:

"The Annual and Supplemental Reports of Michigan Medical Service, dated July 18 and September 22, 1963, as presented to the House of Delegates by Sidney Adler, M.D., President, were considered. We find these to be comprehensive, factual reports, and we take no issue with the facts so presented. The three basic problems of Michigan Blue Shield are: (1) a steady increase in the rate of utilization, (2) increasing loss ratios due to adverse selection, and (3) enrollment problems.

"We are particularly interested in the continuing problem of utilization control. We feel that no person other than a qualified physician, and no group or organization other than one composed chiefly of practicing physicians, is competent to form judgments as to the propriety of any medical service. The Reference Committee would therefore recommend the following realistic approach to utilization control:

"The Michigan State Medical Society should accept the obligation for utilization control. We therefore recommend that The Council appoint members of the Michigan State Medical Society to investigate specific utilization problems referred by Michigan Medical Service or other responsible groups. These physicians should be compensated by the MSMS, and we further recommend that Michigan Medical Service cooperate in defraying the costs of such investigations."

"This Committee takes cognizance of studies currently being made by Michigan Medical Service on merit or experience rating and low-cost contract offerings, and we encourage the continuation of such studies as a possible solution to increasing loss ratios from adverse selection and to enrollment problems."

"The Reference Committee regrets the situation which necessitated litigation leading to the Consent Judgment which at least temporarily resolved an impasse between Michigan Medical Service and the Insurance Commissioner. We deplore the apparent delaying tactics of a government official (the Insurance Commissioner) which threatened the solvency of a non-profit voluntary corporation serving the health needs of the people of Michigan. We also disapprove the imposition of contingencies in the solution of a fiscal problem.

"The Reference Committee approves of the efforts of the President and Board of Michigan Medical Service to keep the corporation informed of the day-to-day developments during the time of the litigation."

The House adopted this report of the Reference Committee.

11. Governor's Address—The Honorable George Romney, Governor, State of Michigan

Following are extracts from the Governor's Address which are of particular interest to physicians:

As physicians you have dedicated your lives to helping others, and certainly you are honored and you are indispensable parts of your communities as a result. I don't know whether these figures are exactly right, but I think they are approximately correct; at least I have seen them several times, namely, that at the time of Christ the average life span was 30 years. In George Washington's day it was 40. At the end of the last century it was 50. At the present time it is over 70. Certainly this remarkable lengthening of life, which is the greatest boon that has come to mankind, is the result of your work and the work of your predecessors and those who have perfected the science of medicine. I commend you for it.

I am particularly conscious of the effort that it takes to become proficient in your field, as a result of having a son-in-law who is just beginning a residency. I don't know how long it will be before he can earn enough to support his wife and two children, but in any event I have had my eyes opened at the length of time it takes to get where he is, and how much longer it will take to become what he has at least given some consideration to, namely, a brain surgeon or a heart surgeon or a specialist in one of those fields. Certainly there are few who realize the tremendous concentration of effort and cost involved in bringing man to your level of ability and saving and lengthening life.

Your State Medical Society and House of Delegates have an enviable record in public affairs as well as medical affairs. You have not only expressed your concern about highway safety but you have also done something about it, and I commend you for the interest you have taken in various activities such as the Cornell studies and the push you gave to getting safety belt legislation, and the interest you have taken in the betterment of auto design and other things relating to motor vehicles and their use.

I can assure you, as one who was formerly active in that industry, that while your recommendations don't get full implementation because in many instances it would be difficult to do so on a practical basis, they are not overlooked; and they have an impact, and they do stimulate effort.

I also commend you for the great interest you have taken in the problems of the aging and in working to make voluntary health insurance plans work, and in working for the pooling of health insurance risks and in furthering new approaches in mental health, and recognizing the importance of all physicians, not just psychiatrists, in this mental health field.

I know that you have formulated some recommendations in connection with the reorganization of State government as a result of our new Constitution, and particularly as it relates to the various health agencies, and I welcome this.

I also want to express appreciation for the important part you took in connection with the approval of the new State Constitution. After all, that didn't get approved by very much of a margin, so your organization and every other one can feel that you supplied the winning margin. I want to express appreciation for your effort, because there isn't any question in my mind but that this new document is going to benefit the people of this State for a long time to come. It is the most important single public event that has happened so far in this century as far as our State is concerned.

There is one other thing I would like to touch on, and that is in this field of voluntary health programs and Kerr-Mills. There are really two things.

I have previously stated my firm belief that physicians should

be reimbursed fairly for services rendered to the State, and that I don't believe physicians should be forced to consider an ever-increasing part of their work as government cases and charity cases, as is now the case in many instances.

I have mentioned the Wayne County situation under Rule 10. I am very anxious to see the Kerr-Mills approach succeed. [*Applause*] I believe it is the soundest approach that has been discussed. I realize that it needs some greater support in Wayne County.

I have been shocked to find, since getting into this position, how many things were not being supported at the level of State commitment. One was the children's hospitals. Back in 1913 the State committed itself to paying the full cost of the hardship cases for unfortunate children. Since the early 1950s this has not been done; as a matter of fact, it goes back farther than that. I have forgotten the exact date now, but in any event we were paying only about 60 per cent. Then in this last budget we undertook to do something about that, and to do something about some of these other commitments.

I can assure you that, as far as I am concerned, it is my desire to see the Kerr-Mills situation corrected as soon as it is at the point priority-wise where that is the thing to do. I make no bones about the fact that in taking office last January I set out to rebuild the public confidence in the fiscal integrity of Michigan, and I believe we have largely done that already. I don't know how the rest of you feel about it, but I believe we have. [*Applause*]

Now, with respect to the voluntary health insurance plans, I am concerned in that area. I don't know that I have an accurate picture; but let me voice my concern for whatever it is worth, so if I am not right you can correct me, and if I am right maybe there are things you ought to do.

The basic picture I get is that there were some studies made of what could be done to improve these programs; but those responsible for them didn't act on some of these recommendations, and so the Insurance Commissioner seizes upon this and uses these things to force those responsible to agree to make some of these changes; and this increases public doubt as to the willingness of those with private responsibility to do what ought to be done in the public interest, and increases public belief that they have got to rely on government.

I think, as I have watched the situation in the past few months, that is about the net of what has happened; and I think that is most unfortunate, because I know from my experience in my sector of private activity—and I don't know your sector, and I can't be an expert in your field—but I have been in certain aspects of private life in America—economic life—well enough to know that part, and I know that what America is today is primarily the result of individuals having been given the freedom to do what they think they can best do to contribute to their own well-being and the well-being of their fellowmen [applause], and to join voluntarily with their fellow associates in given fields of endeavor where as individuals they can't do as much as needs to be done.

The mainsprings of progress in America—the things that have basically built this country—have not been money and government; they have been responsible citizenship in the economic field, and the willingness of responsible citizens and experts in different fields to join together and create voluntary mechanisms to promote the public interest as well as the private interest. That has built America, and this is the thing that is involved in what is going on in America today.

Unfortunately, people all over this country are having their faith in that approach weakened, and their faith in money and government increased. That is why I am so disturbed at what I think has been the experience in your field in connection with these voluntary health programs in the past few months.

From my experience in association work and industry—and in Washington, because I spent about ten years in Washington representing industry—and then about the same length of time heading up the automobile industry's public activities through the Automotive Council for War Production and the Automobile Manufacturers Association, it is my experience that the only way to defeat those who would substitute government and compulsion for the more effective programs based on voluntary cooperation is to out-think them and outdo them in doing those things that clearly need to be done, and thus to be in a position, when a government official comes along proposing something, of being able to say, "This isn't sound, but we have done the things that are sound."

The only defense I know of against this constant reaching into and encroaching into private areas is to do things that are clearly in the public interest, on the private areas and on a sound basis, and thus to have the public respect and support that is needed to resist the effort to encroach and move government in an unsound manner.

On that basis, I think it can be done. (See Resolution 71 for House action regarding the Governor's address.)

REPORTS OF THE COUNCIL

12. Annual and Supplemental Reports of The Council —Chairman of The Council O. B. McGillicuddy, M.D., Lansing

The Council met eight times in the last year for eleven full days, and most of these men devoted ten more days to committee work, and they sat all afternoon from twelve-thirty today until just now in a meeting. None of them slipped out to watch the football game, the reason being that the door was locked. I have never known a more devoted group of men.

The annual report of The Council is in your Handbook. I hope you have read it or at least looked it over, because if you have you will notice that under "Matters Referred for Action by the 1962 House of Delegates" there are five pages of thirty-eight directives plus eight matters which were invited to the attention of Michigan Medical Service. Last year was a most prolific one for the House, and I suspect that this year will be the same. I will wait a moment in the hope that you will all find our supplemental report in your Handbooks.

MEMBERSHIP

On September 1, 1963, the membership of MSMS totaled 7,007 as compared with the total of 6,892 at the same time last year. A breakdown of the current total shows the following:

Active	6,044
Life	462
Associate	343
Retired	122
Military	28
Nonresident	2
Honorary	6
Total	7,007

THE JOURNAL

On July 12, 1963, Editor Emeritus Wilfrid Haughey, M.D., passed away. The MSMS has lost a devoted and talented servant. Since the turn of the century Doctor Haughey had been participating in the leadership of Michigan medicine and his sage advice and counsel will be sorely missed in the months and years to come.

ORGANIZATIONAL ACTIVITIES

Conferences were held in all Councilor Districts during the past two months to transmit the latest information on Michigan State Medical Society activities to Delegates, Alternate Delegates and component society officers. A list of these meetings, indicating dates and places, is part of the addenda to this report.

Since development of The Council's Annual Report in July, The Council has appointed four new committees:

1. The Relative Value Study Committee, Luther R. Leader, M.D., Detroit, Michigan, was created to receive advice and comments of MSMS members regarding the Relative Value Scale. The Committee will make a continuing study of the RVS.

2. The Council has appointed a Committee on Medicine and Religion, Chairman, Richard L. Rapport, M.D., Flint. This Committee will be Michigan's counterpart to the new AMA

Department on Medicine and Religion and will work closely with the national organization and component societies in Michigan. The Committee's goals will be to enhance patient care by means of increased understanding between physicians and clergy regarding the problems of each.

3. A Workmen's Compensation Study Committee, Chairman W. J. Jend, M.D., Detroit, will study the medical testimony aspects of compensation law and make recommendations to The Council and to the Governor's Commission on Workmen's Compensation.

4. The Council also appointed Chairman of Arrangements for the proposed 1965 Health Fair, Don W. McLean, M.D., Detroit.

CONTACT WITH GOVERNMENT AGENCIES

1. The Annual Report of The Council and the Annual Report of the Legal Affairs Committee refer to intensive efforts, over several months, to effect a change in a rule (Rule 10) of the State Social Welfare Commission to assure that Medical Assistance to the Aged patients will not be deprived of the services of their private physicians and care in the hospitals of their choice.

We now report to you that the Social Welfare Commission, on August 29, formally rescinded Rule 10 with an effective date of July 1, 1964, which is the commencement of the next fiscal year for the State of Michigan. After that date, county boards of supervisors need no longer restrict reimbursement to hospitals and physicians for care of MAA patients to levels established for welfare patients (or to levels established for similar care under other programs). Furthermore, the Social Welfare Commission, based upon data provided to it by the MSMS Legal Affairs and Socio-Economic Committees, is presently considering advancing the effective date of abolishment of this Rule to January 1, 1964.

This action makes possible a significant improvement in the operation of the Kerr-Mills MAA Law in Michigan, particularly in Wayne County, where hospitals have heretofore been required to accept only 75 per cent of their cost of care and physicians only 75 per cent of the 1959 Uniform Fee Schedule for Governmental Welfare Agencies under the provisions of the Rule.

2. In mid-June the Michigan Crippled Children's Commission announced that it would no longer support certain elective procedures under its Afflicted Children program unless they were recommended and carried out by Board-certified surgeons. The Council then recommended to the Commission that any physician, functioning in an accredited hospital, be permitted to carry out these elective procedures without any further consultation than that normally required by the accredited hospital in which he functioned.

Following this recommendation of The Council, the Crippled Children's Commission reconsidered its mid-June announcement and has now ruled that elective surgical procedures, in communities where Board-certified specialists are not available, can be performed by the attending physician after he has obtained a second opinion from a colleague who is approved by his own hospital accreditation committee.

3. In 1959 the Michigan Uniform Fee Schedule for Governmental Welfare Agencies was updated by MSMS. The Council believes this should be modernized again to incorporate new procedures and include other revisions that have been made over the years. Therefore, a committee of The Council will be appointed to make necessary revisions in accord with House of Delegates policy.

4. Reorganization of Michigan State Government—The new Constitution was finally and formally adopted on June 20 with the termination of the recount. It takes effect on January 1, 1964. The Legislature then has two years (1964 and 1965) to effect reorganization. If it fails to do so the Governor has a year to recommend his own plan (1966). His plan will take effect unless disapproved by both Houses of the Legislature.

On May 3, 1963 the MSMS Legal Affairs Committee adopted an 8-phase approach to developing information for The Council on State government reorganization. This approach was approved by The Council. It calls for a report to The Council after information has been obtained through informal liaison with all parties involved in the reorganization process.

PHASE 1: A determination has been made of all State Boards, agencies and commissions which are involved in health matters.

PHASE 2: A determination has been made of which MSMS committees are concerned with functions of State government. Each committee chairman (there are 32) has been asked to express the thinking of his committee. Approximately one-half have responded and a second letter of inquiry was sent on September 9, 1963, to those who have not.

PHASE 3: Continuing liaison is being maintained with the Joint Legislative Committee on Implementation of the New Constitution, with Governor Romney's staff and with the Attorney General's office.

PHASE 4: Viewpoints of some chief State administrative officers have been obtained, and plans are under way to discuss their viewpoints with the others. The Legal Affairs Committee is inquiring into the thinking behind presentations made to the Governor by State agency heads (such as the Health Department Plan, Rx-Health).

PHASE 5 of the Committee's approach provides: "When all such information has been obtained through informal liaison, such information will be referred to a committee in accordance with the wishes of The Council, MSMS, for the purpose of developing MSMS policy in regard to governmental reorganization matters."

In *Phase 6*, recommendations will be developed in the light of MSMS policy for grouping of functions within instrumentalities of government; in *Phase 7*, recommendations will be made for consolidation of instrumentalities into principal departments, and in *Phase 8*, legislation will be suggested to accomplish such consolidation.

Insofar as actual implementation of the new constitution by way of legislation is concerned, actual major departmental consolidation (reorganization) is not of first priority. Legislative action in such areas as the election and judicature codes, and budgetary matters, must be accomplished first, and may be taken up at the special fall taxation session.

Thus, to date the Attorney General (on June 28 and August 14) has referred to the Legislature those reorganization sections of the new Constitution which he feels will require new statutes in 1964. The Committee (The Joint Legislative Committee on Implementation of the New Constitution, created by concurrent resolution of the Senate and House; Rep. Rollo Conlin, R-Tipton, Chairman) has held preliminary hearings, confining itself to the Civil Rights and Highway Commissions, and to education. The Governor's staff commenced actual review and "hard thinking" on agency presentations in mid-September. It is planned to "phase in" reorganization rather than to do it all at once, and no decision has been made as to the logical sequence of the reorganization.

The MSMS is deeply concerned with the matter of obtaining the developing viewpoints of all involved parties, of integrating the information thus obtained, and of summarizing and condensing it. This will then be presented by the Legal Affairs Committee in meaningful report form to The Council. This is a long-range and on-going project of a complexity requiring continuity of approach.

However, there are certain fundamental and basic philosophical questions which arise in the consideration of various present activities of State government. Inasmuch as the schedule for reorganization contemplates study during 1964, culminating in legislative action during the 1965 legislative session, the MSMS Legal Affairs Committee, to best continue its work in this area, needs the guidance of the House of Delegates with respect to matters of a highly controversial nature.

One such basic question, for example, involves whether the mental health agency should (1) be made one of the final twenty principal departments by itself, (2) whether it should be combined with the Department of Health, or (3) combined with

some other agency. Similarly, the question arises: Should the present Social Welfare Department be (1) combined with the Department of Health, (2) made a single one of the twenty principal departments, or (3) combined with a department other than Health? Should the health aspects of welfare (as differentiated from provision of food, clothing and shelter) be (1) transferred to the Department of Health, or (2) retained in the Welfare Department? If the Department of Health is to emerge as a separate one of the ultimate twenty principal departments, should its services be limited, and if so, to what extent?

The deliberation of the House of Delegates, as the policy-making body of MSMS, will be invited to the foregoing fundamental and controversial questions.

SOCIAL SECURITY POLL

The 1962 House of Delegates instructed that MSMS members be polled regarding their attitude toward the inclusion of physicians under Social Security. The results of the poll were reported to members as follows:

"Do you favor inclusion of physicians under Social Security?"

YES	3,033
NO	1,845
NO OPINION	20
TOTAL	4,964

As instructed by this House, this information was transmitted to the House of Delegates of the AMA for its action.

HEADQUARTERS ORGANIZATION—THE NEW TEAM

As you know, William J. Burns is retiring as Executive Director of MSMS on December 31, 1963, following almost twenty-nine years of distinguished service. The Council recognized Mr. Burns for his outstanding work at a luncheon held in his honor during the Midsummer Session of The Council, July 19, 1963.

Due to Mr. Burns' retirement from active duty and also the passing of MSMS Editor Wilfrid Haughey, The Council has named a new team to assist it in the administration of MSMS. The action was taken by The Council at the Midsummer Session and a special letter was mailed to all members of the Michigan State Medical Society informing them of the following appointments: Hugh W. Brenneman, Executive Director; Warren F. Tryloff, Associate Executive Director; C. J. Tupper, M.D., Editor of The Journal; Herbert A. Auer, Managing Editor of The Journal.

FINANCIAL REPORT

December 1, 1962, through August 31, 1963

ACCOUNT	Income to 9/1/63	Expenses to 9/1/63	Balance at 9/1 63
General Fund	$224,919.53	$172,900.87	$ 52,018.66
Annual Session	29,782.00	9,808.93	19,973.07
Michigan Clinical Institute	14,255.00	17,601.32	3,346.32 Cr.
The Journal	81,604.50	91,534.56	9,930.06 Cr.
Public Education	41,762.83	23,665.28	18,097.55
Department of Economics	29,792.65	15,709.78	14,082.87
Professional Relations and Public Service	32,799.31	20,957.52	11,841.79
Rheumatic Fever	2,057.01	1,343.40	713.61
Headquarters Maintenance and Debt Retirement	89,485.12	69,404.95	20,080.17
House of Delegates	17,875.95	11,410.33	6,465.62
MSMS Savings Reserve	19,378.52	—0—	19,378.52
AMA-ERF Fund*	49,821.18	—0—	49,821.18
TOTALS	$633,533.60	$434,336.94	$199,196.66
Less: Notes Payable at Michigan National Bank—Paid from Current Income, 1963 (not including $33,000 paid on building debt)			67,000.00
Balance			$132,196.66

* In February, an advance payment of $9,817.91 was made to AMA-ERF; thus the total collected amounts to $59,639.09, as of September 1, 1963.

At this time I beg permission of the House of Delegates to call upon the Chairman of our Finance Committee, Doctor Warren W. Babcock, to give you in capsule form exactly what these accounts and figures represent, the amount of money we have on hand, where it is, and what we have to do with it.

Doctor Babcock: The report of the MSMS financial position is printed in the Supplemental Report of The Council (printed above) which is before you. MSMS as of September 1 is in good position. It is operating within its budget and income.

As a result of the House of Delegates action of 1962, we have in the past months collected as a part of membership dues to August 31, 1963, $59,639.09, which, with any additional collections through November 30, the end of the fiscal year, will be turned over to the American Medical Association Education and Research Foundation as the contribution from Michigan doctors of medicine for use by the two Michigan medical schools for student aid.

The financing of the Headquarters building has been reported each year since construction began. On September 1, a year ago, we had notes due at Michigan National Bank in the amount of $100,000. On September 1 of this year, these have been reduced to only $50,000. However, as in the past, it will be necessary to reborrow some of these funds during the closing months of the year and repay in the early months of 1964 when dues income is high. We have in past years been able to save annually between three and four thousand dollars in interest payments by borrowing funds only as needed.

At the end of fiscal 1961, outstanding notes totaled $200,000.
At the end of fiscal 1962, outstanding notes totaled $150,000.
At the end of fiscal 1963 (November 30), we anticipate outstanding notes totaling $125,000.

However, this year we have established a liquid Savings Reserve of approximately $20,000, which may be used to further reduce indebtedness.

At the present rate of debt reduction, all notes will be paid no later than 1966.

COMMUNITY HEALTH WEEK

The first observance of Community Health Week in Michigan will be October 20-26, 1963. The AMA House of Delegates urges participation in this event by all county medical societies as an outstanding means of cooperation between the medical profession and the health services and agencies in each community.

The Council has approved MSMS participation and recommends that component societies actively participate also.

A recommendation on this subject follows.

MSMS GROUP INSURANCE PROGRAMS

1. MSMS Group Term Life Insurance Program as of September 9, 1963. The report for the last twelve months is as follows:

Number of members now insured	1,390
Amount of insurance in force	$13,360,000
Premiums collected during past year	129,544
Claims paid during past year	39,500
Total death claims paid	283,500
Claims now pending	10,000
Number of members now under waiver of premium for disability: 4, for	35,000

The above figures include 63 members who elected to replace their term insurance with permanent insurance. The amount of permanent insurance in force is $565,000 with a premium volume of $16,524.

MSMS Group Health and Accident Plan. The report for the last twelve months is as follows:

Number of insured members	2,028
Accidental death claims	None
Loss of time payments	449
Amount of payments	$126,808.46
Average number of payments per month	37
Percentage of insured members receiving payment during the year	9.5%
Claim reserves	$105,750.00

All claim payments are increased by 10% due to favorable experience.

1965 MSMS CENTENNIAL CELEBRATION

As The Council reported in its Annual Report, the development of plans for the MSMS Centennial Celebration in 1965 has been authorized. The site will be Detroit, where MSMS was founded. Cobo Hall will be used for the scientific program and exhibits.

Also, plans for a Michigan Health Fair during our Centennial Year are being developed. The Health Fair Arrangements Committee will make a special report to this House of Delegates later on the agenda. The Council concurs in the recommendations of the Health Fair Arrangements Committee; however, because of the tremendous scope of this undertaking, The Council believes that this project requires consideration by this House of Delegates.

Our Arrangements Committee has and will receive valuable advice from the Kent County Medical Society doctors who did such an outstanding and commendable job in making the May 1963 Grand Rapids Health Fair such a success. Dr. J. R. Lentini, General Chairman of that Fair, is consultant to the MSMS Health Fair Arrangements Committee.

A recommendation on this subject follows.

RELATIONSHIPS OF PHYSICIANS NOT IN PRIVATE PRACTICE TO ORGANIZED MEDICINE

The American Medical Association House of Delegates recommendation that all M.D.s be included in the work of organized medicine has been studied and supported by The Council. Accordingly, a resolution on this subject, to implement the AMA recommendation, will be presented to this House of Delegates for its consideration.

STUDENT DELEGATES TO MSMS HOUSE OF DELEGATES

During the past year The Council has reviewed the MSMS relationship with and support of the Student American Medical Association, Michigan Chapters. Accordingly, The Council authorized an increase of financial support of the SAMA Chapters at Michigan's two medical schools.

This House of Delegates has recognized the importance of liaison with Michigan medical students, and for several years the junior and senior classes of Michigan's two medical schools have been invited to send three representatives each to sessions of the MSMS House of Delegates. However, no specific provision is made to invite representatives of the two SAMA organizations.

Therefore, to insure representation from each Michigan SAMA Chapter, The Council respectfully recommends that the procedure for inviting representatives from the medical schools be revised as follows: (1) Invite two representatives each from the junior and senior classes of the two medical schools, and (2) invite two representatives from each of the SAMA Chapters, beginning at the 1964 Annual Session.

A recommendation on this subject follows.

RECOMMENDATIONS OF THE COUNCIL

We respectfully invite your attention to six recommendations in the original Annual Report of The Council in your Handbook, as follows:

1. That The Council be authorized to arrange Councilor Conferences prior to the 1964 Annual Session and thus share pertinent information with the delegates, alternate delegates and component society officers, as during the past five years.

2. That the House of Delegates urge component societies to continue to hold "County-State Society Night programs" to provide officers and representatives of MSMS an opportunity to discuss mutual problems with component society members. A growing number of such meetings proved valuable during 1962-63.

3. That the House of Delegates again instruct that MSMS representatives be sent to Washington, D. C., in 1964 on "Michigan Day."

4. That the House of Delegates once again encourage all component societies to send delegations of members to Washington, D. C., to discuss legislative matters with their elected representatives.

5. That the House of Delegates participate actively in the forthcoming Centennial Celebration in 1965 and include in its considerations possible special observances by the House of Delegates.

6. That the House of Delegates highly endorse the AMA-MSMS campaign, "Operation Hometown," and urge support and participation by all MSMS members.

Further, The Council wishes to present three additional recommendations in this Supplemental Report:

7. That the House of Delegates support the recommendations of the Michigan Health Fair Arrangements Committee.

8. That the House of Delegates adopt the following procedure for medical student participation in MSMS Annual Session activities: (a) Invite two representatives each from the junior and senior classes of the two medical schools, and (b) invite two representatives from each of the SAMA Chapters, beginning at the 1964 Annual Session.

9. That the House of Delegates encourage component societies to participate in the 1963 Community Health Week.

The Reference Committee on Reports of The Council, R. K. Whiteley, M.D., Chairman, presented the following report:

"Your Reference Committee considered the Annual Report of The Council as published in the Handbook, and Supplementary Report of The Council dated September 22, 1963. Your Reference Committee was impressed by the tremendous amount of work that has been accomplished by members of The Council and members of its various committees, and expresses its sincere thanks to them.

"In addition, we commend Mr. Lester P. Dodd, Legal Counsel, Dr. Wilfrid Haughey, late Editor of THE JOURNAL, and members of the administrative staff of the Michigan State Medical Society for their splendid efforts on behalf of our Medical Society.

"The Reference Committee wishes Wm. J. Burns good luck in his retirement, and wishes to commend The Council on their new headquarters organization and team.

"Recommendations of The Council: The first four recommendations have been reaffirmed for the last several years, and your Reference Committee recommends that they become part of the Councilor procedure."

"5. That the House of Delegates participate actively in the forthcoming Centennial Celebration in 1965 and include in its considerations possible special observances by the House of Delegates.

"The Reference Committee has recommended that the Speaker of the House appoint an advisory committee from the House of Delegates to act with the committee of The Council."

Recommendations 6, 7, and 8 were approved.

"9. This recommendation was approved with the following amendment: That the House of Delegates encourage component societies to participate in the 1963 Community Health Week and the 1965 Centennial."

The House adopted this report of the Reference Committee.

13. Michigan Health Fair—Report of Chairman D. W. McLean, M.D., Detroit

First, I want to express the appreciation of our Arrangements Committee to all those who took part in the Kent Medical Foundation Health Fair. It was a superb job. Personally, I would like to thank Dr. Lentini, who was the General Chairman of Arrangements for that Fair, for not only the accomplishments of the Fair but for the fact that he has consented to serve as a consultant to our Committee, and for the very considerable help he has already given to us.

This is the report on the Michigan Health Fair, 1965:

Your Council has planned for a State-wide Health Fair as a climax of our Centennial Celebration, culminating the MSMS five-year Presidential Program.

Toward that end we will discontinue participation in the State Fair for the years 1963 through 1965 with the intention of devoting such resources to a larger and more comprehensive exposition of our health program. This Fair is to be strictly noncommercial, and each exhibit is to be oriented to an educational program in the basic sciences. We plan this Fair as a

demonstration of the accomplishments of modern medicine in promoting the health and physical well-being of people of all ages.

Our fundamental appeal will be to our youth from junior high through college, to show them the structure and function of man, to give them a view of what they themselves are and what they can become—for all depends on man; only through man himself can any advance be made.

We hope to develop an educational program for the year 1964-65, based upon our exhibits which will be of help to schools in teaching the biological sciences. In this way we hope to prepare the students for the exhibits and demonstrations they will find in the Fair. We plan to make this Fair a climax to the school's biological program at all levels.

We also hope to stimulate the desires and ambitions of youth with a demonstration of the opportunities, advantages and rewards for the many careers in the medical sciences.

For those of middle age we will display the ways in which medicine has added energetic, productive and fruitful years; and for the aged, the preservation of health and stamina, to savor and enjoy the rewards of life.

We believe this project offers the greatest opportunity for the general public to become better acquainted and to appreciate the advances medicine has made and their profound effect on every phase of our lives. In other words, we are planning to bring medicine home to the family.

Public interest in a Health Fair is stimulated through two mechanisms: first, exhibits; second, activities. Each is of about equal value. The exhibit teaches and the activity stimulates and insures individual participation in the learning process. We plan a judicious combination of exhibits and activities.

Much work has already gone into this project and we have scarcely started. The initial organization of our Arrangements Committee consists of the following members as chairmen of their respective committees:

Charles P. Polentz, M.D., Chairman, Committee on Exhibits.

Francis P. Rhoades, M.D., Chairman, Committee on Activities.

James D. Fryfogle, M.D., Chairman, Committee on Traffic.

Remus G. Robinson, M.D., Chairman, Committee on School Participation.

James J. Lightbody, M.D., Chairman, Committee on Professional Relations.

Donald N. Sweeny, Jr., M.D., Chairman, Committee on Publicity.

Luther R. Leader, M.D., Chairman, Committee on Finance.

Joseph R. Lentini, M.D., Consultant.

In addition to the personnel of these committees, which will be for the most part local, we recommend the appointment of a three-member coordinating committee in all component county societies, such committees to work with schools and paramedical groups in their local areas and function through the General Committee on Arrangements.

I would now like several of the members of our Arrangements Committee to give you a few of the details of the projected functions of their committees.

I will ask Dr. Charles P. Polentz, Chairman of the Committee on Exhibits, to tell you something of his plans for the Fair.

Charles P. Polentz, M.D. [Wayne]: The Exhibit Committee will present the face of medicine in many aspects. It is our desire to involve the whole community with a special appeal to younger persons from a career viewpoint.

We will have exhibits directed to the general public. In doing so, industry will have an opportunity to display its contributions to medicine. These might be exemplified by the heart-lung machine developed at the G. M. Technical Center or a silastic prosthesis from Dow Chemical. Industrial health and hygiene and safety might well be portrayed. The pharmaceutical manufacturers could present many interesting facets which would have a wide appeal.

Public contributions from the Armed Forces, the National Institutes of Health, the National Aeronautics and Space Administration, and the Atomic Energy Commission are available. Certainly instrument makers, that is, x-ray and electronic, can tell a most fascinating story. We shall include the Public Health and other agencies which promote health. We will ask our dental friends to provide an interesting display. The veterinarians will provide a special spark of interest by live animal surgery.

In a friendly fashion our aim is to educate, to promote a more general knowledge of what is available, and provide some information as to the sources. This will have a broad appeal and reflect to our benefit.

D. W. McLean, M.D.: Dr. Remus G. Robinson, Chairman of the Committee on School Participation, is now in Europe, and Dr. J. R. Lentini has kindly consented to give a report for Dr. Robinson.

J. R. Lentini, M.D. [Kent]: At the request of Dr. R. G. Robinson, Chairman of the Committee for School Participation, I come before you to substitute for him in making this brief presentation.

The proposed Health Fair, I am sure, must be for you (as it is for me) a most thrilling and exciting project. As General Chairman of the Kent Medical Foundation Health Fair, held in Grand Rapids in May of this year, I can say to you that for all of us who participated it was a most rewarding experience.

On recommendation of school authorities, tours were arranged for students from the 6th through the 10th grades. These students totaled 38,488 plus approximately 1,540 teachers, and they came from 245 schools. These figures do not include 11th and 12th grade and college students who were admitted free, nor those who returned during the evening hours, with or without parents, for the second and even a third time. Conservatively it can be said that student participation numbered 80,000.

Comments about the Kent Medical Foundation Health Fair have been excellent. School authorities thought it superb. Public and student interest was tremendous.

I have a letter from the Director of the Grand Rapids Foundation who granted a matching fund to help put on the Health Fair, stating:

> I was tremendously impressed in the Kent Medical Foundation Health Fair, staged in Grand Rapids May 19-24, 1963. My interest was three-pronged—(a) as a former educator, (b) as Director of the Grand Rapids Foundation, which made a sizable financial grant to the Fair, and (c) as a citizen spectator.
>
> Thousands of students in grades 6 to 10 had a prior-conditioned explanation of the Fair and a conducted tour through it. The lessons they learned about health, disease, and anatomy from the tour and from subsequent discussion in their classrooms were an invaluable experience. The many thousand additional adults who attended the Fair were likewise greatly benefited.
>
> From all three of my vantage points mentioned above, I commend the tremendous work which was done in presenting the Fair, and I consider it a major contribution in 1963 to the welfare of this community.
>
> s/ Howard Wickett, Director

Can you imagine, gentlemen, what an impact an MSMS Health Fair will have upon the greater student population the Wayne County area and the eastern part of the State can provide? I can't begin to express the educational opportunity you will offer the family in sponsoring this Fair.

More than this, a Health Fair will provide an opporutnity for the State Society to serve in an advisory and consulting capacity for careers, job opportunities to advance health and medical research, and for educating the student and public as well as in all phases of the health and scientific fields.

I make a plea, then, gentlemen, on behalf of the Health Fair Arrangements Committee, that this august body sanction and endorse the presentation of a Health Fair.

D. W. McLean, M.D.: Dr. James J. Lightbody, Chairman of the Committee on Professional Relations, will tell us something of his plans regarding the various professional groups that will be invited to participate in the Fair.

The Speaker: The Committee on Professional Relations will concern itself mainly with stimulating interest of other professional people in the Health Fair. There are a great number of organizations of a paramedical or ancillary nature who would be able to assist us in setting up programs, presenting exhibits, and in general to take a really active part in this program.

It is planned to contact the following groups to promote the

existence of the Health Fair and to attempt to get their complete support and active particiation.

1. State and local Nursing Association—R.N.
2. State and local Nursing Association—Practical Nurse
3. State Medical Assistants
4. State and local Woman's Auxiliary
5. Hospital auxiliaries
6. State and local dental societies
7. State Pharmaceutical Association
8. Retail Druggists
9. Laboratory technicians
10. State and local Boards of Health
11. Physical therapists
12. Occupational therapists
13. Michigan Hospital Association
14. Pharmaceutical companies—national and State
15. Michigan Health Council
16. University of Michigan Medical School
17. Wayne State Medical School

These and many other organizations would be asked to provide exhibits or at least actively support our plans for the Health Fair, and it is planned to utilize the facilities and knowledge of the Michigan Health Council particularly in contacting local community health groups and foundations in the State of Michigan.

The cost of their promotional activities is unknown at this time.

D. W. McLean, M.D.: Dr. Luther R. Leader is Chairman of the Committee on Finance, and will now tell you something of our plans for financing this project.

L. R. Leader, M.D.: For two important reasons, the Committee recommends that the Health Fair be operated on a free admission basis.

First, when no admission is charged, Cobo Hall rental rates drop substantially because the show is then presumed to be a nonprofit venture.

Second, we feel that a "no admission" policy will reinforce the public service and educational aspects of the MSMS role in sponsoring the event.

Although there will be no gate receipts, exhibit space will be sold to industrial firms.

No charge for exhibit space will be made to voluntary health organizations, universities, hospitals and the like. However, these exhibitors will be required to pay all shipping, installation and breakup costs.

Expense items of the Michigan Health Fair include: Printing; Cobo Hall rental; decorating and electrical expense; advertising; insurance; postage-telephone; equipment, and so on.

We recommend that the MSMS retain control of the Health Fair by being the sole sponsor, but enlisting the cooperation of other groups and organizations.

We anticipate a total expenditure for the Health Fair of approximately $100,000.

The Committee recommends that the Health Fair be financed as follows:

$35,000 allocated to the project by MSMS.

$35,000 in matching grants from foundations or organizations.

$30,000 income from sale of exhibit space.

I would point out that the MSMS contribution would mean that only $17,500 need be allocated in the 1964 budget and a similar sum in the 1965 budget. In addition, you should know that The Council has withdrawn from participation in the Michigan State Fair in 1963, 1964 and 1965, in anticipation of the Health Fair, thus making it possible to allocate what would normally be State Fair funds to the Health Fair.

Our Committee has no intention of recommending a special assessment.

D. W. McLean, M.D.: Thank you, Dr. Leader.

Ladies and gentlemen, the bare bones of organization have taken form. The muscles, nerves and other soft parts we will contribute, but only from you, this House of Delegates here assembled, can come the breath of life.

Our Committee sincerely and respectfully requests not only your approval but also your enthusiastic cooperation in this important project of bringing modern medicine home to all the people of Michigan.

The Reference Committee on Ways and Means, N. L. Avery, M.D., Chairman, recommended approval of this report.

The House adopted the recommendation of the Reference Committee.

COMMITTEE REPORTS

14. Annual and Supplemental Reports of Council Committees

All these reports have been printed in the Delegates' Handbook and/or The Journal.

(1) ALCOHOLISM AND DRUG ADDICTION
(2) AWARDS
(3) CONFERENCES ON HEALTH CARE
(4) ORAL POLIO VACCINE
(5) STUDY OF PODIATRY
(6) SURVEY OF UTILIZATION OF HEALTH INSURANCE
(7) POLICIES OF THE COUNCIL

The Reference Committee on Reports of The Council, R. K. Whiteley, M.D., Chairman, recommended approval of the above reports.

The House adopted this recommendation of the Reference Committee.

(8) COURSES ON MEDICAL ECONOMICS AND ETHICS

The Reference Committee on Reports of The Council recommended approval of this report with special commendation to Chairman C. Howard Ross, M.D., and suggested that a similar program be instituted at Wayne State University College of Medicine.

The House adopted this recommendation of the Reference Committee.

(9) DISASTER MEDICAL CARE

The Reference Committee on Reports of The Council recommended approval of this report and encouraged the Committee to clearly define disaster medical care at the state, county and city level.

The House adopted this recommendation of the Reference Committee.

(10) STUDY ESTABLISHMENT OF LOAN FUND FOR NEW PHYSICIANS

The Reference Committee on Reports of The Council recommended approval of this report with emphasis on the Committee's recommendation to component societies regarding reduction in dues for physicians beginning practice.

The House adopted this recommendation of the Reference Committee.

(11) HOSPITAL RELATIONS

The Reference Committee on Reports of The Council recommended approval of this report except reference to 1962 Resolution No. 40 (See 1963 Resolution 65 on this subject.)

The House adopted this recommendation of the Reference Committee.

(12) MEDICAL CARE INSURANCE

The Reference Committee on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, presented the following report:

"The first portion of this report has to do with Resolution No. 11 passed by the 1962 House of Delegates to improve the

operation of the Kerr-Mills Law in Michigan. We are pleased with the work done by all groups involved in the implementation of this resolution. We also congratulate The Council of the Michigan State Medical Society, its staff, the Legal Affairs Committee and the Wayne County Medical Society in the efforts specific to this regard."

The House adopted this portion of the Reference Committee report.

* * *

"The second part of the report dealt with an evaluation of the relationship between the Michigan State Medical Society and Michigan Medical Service. The Reference Committee recognizes the importance of close liaison between Michigan Medical Service and the Michigan State Medical Society.

"We have studied the seven recommendations of the MCIC ad seriatim and propose the following actions:

" 'Recommendation 1: That the House of Delegates and The Council of the Michigan State Medical Society reaffirm its confidence in Michigan Medical Service and continue to support Michigan Medical Service.' The Reference Committee recommends approval of this recommendation."

The House adopted this portion of the Reference Committee report.

* * *

" 'Recommendation 2: That Michigan State Medical Society and Michigan Medical Service improve communication between the two groups by the development of a liaison committee composed of representatives of each organization, such meetings to be held at regular intervals for the purpose of considering problems of mutual interest. The representative of the Michigan State Medical Society should report regularly to The Council of the Michigan State Medical Society, and the liaison representatives of Michigan Medical Service to either the Executive Committee or the Board of Directors of Michigan Medical Service.'

The Reference Committee recommended disapproval of Recommendation No. 2, "since the officers of Michigan Medical Service now regularly report to The Council of the Michigan State Medical Society, and since your Reference Committee feels that formation of another committee would be unnecessary and a reduplication of effort."

The House adopted the recommendation of the Reference Committee.

* * *

" 'Recommendation 3: That the Michigan State Medical Society develop a program in cooperation with Michigan Medical Service to evaluate the utilization of medical services and such other matters as may arise through the creation of regional review committees.' "

The **Reference Committee** recommended no action upon Recommendation No. 3 in view of the previous recommendation of this Committee relative to utilization control.

The House adopted this portion of the Reference Committee report.

* * *

" 'Recommendation 4: That the Michigan State Medical Society encourage its members to cooperate with the Michigan Medical Service Program to provide service benefits.' "

The **Reference Committee** recommended approval of recommendation No. 4.

The House adopted this portion of the Reference Committee report.

* * *

" 'Recommendation 5: That the Michigan State Medical Society and Michigan Medical Service cooperate in a program of education for subscribers, management and labor concerning their interests in the proper utilization of service benefits.' "

The Reference Committee recommended approval of recommendation No. 5.

The House adopted this portion of the Reference Committee report.

* * *

" 'Recommendation 6: That the Michigan State Medical Society encourage Michigan Medical Service to continue its studies of experience rating and the development of new contracts including deductible plans and the use of riders maintaining the service benefit principle.' "

The Reference Committee recommended approval of recommendation No. 6.

The House adopted this portion of the Reference Committee report.

* * *

" 'Recommendation 7: That Michigan Medical Service consider placing limitations on M-75 benefits. It would appear to be unreasonable to expect doctors to control benefits that are being sold as unlimited by the Plan. We would expect that some dollar limits would be placed on those benefits which would have shown the most utilization and, when these dollar limits are exceeded, that the subscriber must participate substantially in the cost of subsequent benefits.' "

The Reference Committee recommended disapproval of recommendation No. 7 because it proposed a change in the present M-75 contractual agreement with the subscribers of Michigan Medical Service, although the Reference Committee did not disapprove of the concept of subscriber participation either in the form of co-insurance or deductible items.

The House adopted this portion of the Reference Committee report.

The Reference Committee on Reports of The Council recommended approval of the reports of the following committees:

(13) MEDICAL MANPOWER RECRUITMENT

(14) LIAISON WITH MICHIGAN STATE BOARD OF REGISTRATION IN MEDICINE

(15) LIAISON WITH MICHIGAN STATE NURSES ASSOCIATION

(16) LIAISON WITH MICHIGAN ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, INC.

(17) RECRUITMENT OF SUPERIOR MEDICAL STUDENTS AND NEED FOR FINANCIAL AID

(18) LIAISON WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

(19) REHABILITATION

(20) LIAISON WITH STATE BAR OF MICHIGAN

(21) LIAISON WITH STATE EXECUTIVE OFFICE

(22) VETERANS AFFAIRS

(23) PROBLEMS OF THE INDIGENT OR ILL PHYSICIAN

(24) CENTENNIAL

(25) ADVISORY TO COORDINATOR OF CENTENNIAL

(26) REPRESENTATIVES TO MICHIGAN SOCIETY OF NEUROLOGY AND PSYCHIATRY AND MICHIGAN PSYCHOLOGICAL SOCIETY

(27) REPRESENTATIVES TO JOINT COUNCIL TO IMPROVE HEALTH CARE OF THE AGED

(28) AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION—MICHIGAN CHAIRMAN

(29) REPRESENTATIVES TO PERMANENT CONFERENCE COMMITTEE

The **Reference Committee** on Reports of The Council approved the above reports.

The House approved the action of the Reference Committee.

15. Annual Reports of MSMS Standing Committees

All these reports have been printed in the Delegates' Handbook and/or The Journal.

(1) ADVISORY COMMITTEE TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

The Reference Committee on Reports of Standing Committees, R. V. Taylor, M.D., Chairman, recommended that the report be filed and the Committee commended.

"The request that space be found under the roof of the Michigan State Medical Society building was felt inappropriate since The Council has established an advisory committee on space utilization to make recommendations in this area."

The House adopted the recommendation of the Reference Committee.

(2) ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

The Reference Committee on Reports of Standing Committees approved the suggestion that there be renewed attempts to organize areas in which the Woman's Auxiliary is not presently organized, and also approved the suggestion that local units of the Woman's Auxiliary review their programs of activities and functions in consultation with their district councilor and local county society officers, as well as officers of the State Auxiliary. It was emphasized that members of the Michigan State Medical Society should give further assistance to the Woman's Auxiliary.

The House adopted this report of the Reference Committee.

(3) ETHICS COMMITTEE

The Reference Committee on Reports of Standing Committees recommended that this report be filed and the Committee commended for its year's activities.

The House adopted this recommendation of the Reference Committee.

(4) LEGAL AFFAIRS COMMITTEE

The Reference Committee on Reports of Standing Committees presented the following report:

"This report encompasses a tremendous volume of work by the Committee and staff with the assistance of Mr. Lester P. Dodd, Legal Adviser. The Michigan State Medical Society is fortunate in the dedicated and effective work of this Committee.

"The Committee reported that a number of proposals, endorsed and supported by the Michigan State Medical Society, were enacted into law in 1963. Of perhaps even greater importance was the statement that an even greater number of undesirable health proposals were properly rejected by the lawmakers, who did not enact any legislation which was inimical to the best health interests of the people of Michigan.

"The Reference Committee believed it was particularly important that action was taken by the Michigan Legislature concerning five resolutions from the 1962 House of Delegates.

"Especially noteworthy is the passage of 'Good Samaritan' legislation and legislation authorizing the Michigan Crippled Children's Commission to reimburse hospitals for the full audited cost of care. Every delegate and member of the Michigan State Medical Society is urged to read in detail the annual report of the Committee on Legal Affairs."

The Reference Committee recommended approval of this report and the highest commendation of the entire Committee for its tremendous accomplishments.

The House adopted this recommendation of the Reference Committee.

(5) COMMITTEE ON SOCIO-ECONOMICS

The Reference Committee on Reports of Standing Committees presented the following report:

"The Committee wishes to emphasize the importance of the Socio-Economic Committee's function, and to recommend that this report also be read in detail.

"From a series of workshops, the Socio-Economic Committee re-emphasized 'Tenets of Belief and Principles' guiding medicine. It was felt by the Reference Committee that these principles might well be reaffirmed and approved by the Michigan State Medical Society.

"The Annual Report of the Committee on Socio-Economics pointed out guidelines which were derived from the same workshops, and reviewed the work of the Michigan State Medical Society Department of Socio-Economics. It should be particularly emphasized that the Michigan State Medical Society Department of Socio-Economics had an extremely productive year and is one of the few and perhaps the only department of its kind in any state medical society.

"Dr. H. F. Falls, Chairman of the Committee on Socio-Economics, stated that the work of the Committee was made infinitely easier and more effective because of the excellent work of Mr. Richard Campeau, Research Director, and Clyde C. Hardwick, Ph.D., Economic Consultant. The Michigan State Medical Society is especially fortunate to have these individuals on its staff.

"The Reference Committee recommends that the annual report of the Committee on Socio-Economics be filed, and that the Committee accept the appreciation of the Michigan State Medical Society and its commendations for a job well done."

The House adopted this recommendation of the Reference Committee report.

(6) ADVISORY COMMITTEE OF PAST PRESIDENTS

The Reference Committee on Reports of Standing Committees recommends approval of the report as published.

The House adopted this recommendation of the Reference Committee.

(7) COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

The Reference Committee on Reports of Standing Committees recommended that this report be filed and the Committee be commended for its activities, and that the State Medical Society express its gratitude to all participants in the program for their excellent teaching contributions.

The House adopted the recommendation of the Reference Committee.

(8) COMMITTEE ON PROFESSIONAL INSURANCE PLANS

The Reference Committee on Reports of Standing Committees presented the following report:

"The Committee on Professional Insurance Plans reviewed the question of Blue Cross coverage for widows of MSMS members. It was determined that it was not possible in a community-rating program to offer group benefits and rates to the widows.

"The Committee on Professional Insurance Plans recommended that the Michigan State Medical Society provide travel accident insurance for MSMS officers and staff members as designated by The Council."

The Reference Committee concurred in this recommendation.

"Recommendation No. 3 from the Committee on Professional Insurance Plans recommended that the excellent liaison established with the Michigan Chapter of the health insurance industry be continued, and that the Michigan State Medical Society Committee on Professional Insurance Plans provide MSMS liaison with the health insurance representatives."

The Reference Committee concurred in this recommendation.

"The Committee on Professional Insurance Plans offered its services to study any proposed legislation regarding the acceptability and desirability of a "pooling" mechanism for high-risk senior citizens.

"The Committee recommends that The Council instruct its Legal Affairs Committee to continue work to encourage and assist the Michigan Chapter of the health insurance industry to develop and introduce acceptable necessary enabling legislation to permit the creation of health insurance pooling plans in Michigan.

"The Committee Report further recommended that The Council accept the proposed major medical plan offered MSMS members by Health Service, Inc., and Medical Indemnity of America, and serviced by Michigan Blue Shield. The Committee reported diligent study of this matter, and found the proposed benefits and rates more favorable than could be obtained from a commercial carrier.

"The Committee Report further recommended that The

Council ask the 1963 House of Delegates for (1) authority to complete the study of the two or more proposals, (2) to enter into a contract for the best possible program, and (3) to make it available to MSMS members as soon as possible.

"The Report also discussed supplemental life insurance for MSMS members and families. There was also a review of correspondence from MSMS members and a discussion of self-employed retirement plans."

The Reference Committee on Reports of Standing Committees recommended approval of the entire report.

The House adopted this report of the Reference Committee.

(9) COMMITTEE ON PUBLIC HEALTH

The Reference Committee on Reports of Standing Committees presented the following report:

"Action on a recommendation of the Public Health Committee to The Council that it endorses the AMA International Health Program, was deferred pending further action by The Council.

"Concerning Resolution No. 8 of the 1962 House of Delegates, it was the recommendation of the Public Health Committee that attempts to evaluate the medical care patients received in physicians' offices or patients' homes would not be feasible at this time. The Committee therefore recommended that The Council review the results of the Kalamazoo and Blue Cross studies, and suggested that, if a broader evaluation seemed necessary, funds be sought from one of the foundations.

"The Committee on Public Health reported on MSMS Resolution No. 19, entitled 'Function of the Public Health Service.' The Committee felt there were statutory responsibilities of State and local health departments that must be observed and required further study.

"The Committee on Public Health studied Resolution No. 60 from 1962, and recommended to the MSMS Council that a committee be formed to study the matter, but no further action was taken since other MSMS committees were already involved in such a study.

"The Committee on Public Health reviewed the purposes and personnel of their Committee and made recommendations for changes in the personnel composing the Public Health Committee. The Reference Committee approved these recommendations, and recommends their referral to the Committee on Constitution and Bylaws."

The Reference Committee on Reports of Standing Committees recommended approval of this report and commended the Committee for its responsible and faithful service.

The House adopted this recommendation of the Reference Committee.

(10) COMMITTEE ON CANCER CONTROL

The Reference Committee on Reports of Standing Committees recommended that this report be approved in its entirety, with the recommendation that if the development of an illustrated booklet on cytology program required an excessive unbudgeted expenditure, this be referred to the Finance Committee and if, necessary, the Ways and Means Committee.

The House adopted this recommendation of the Reference Committee.

(11) COMMITTEE ON CARDIAC DISEASE CONTROL

The Reference Committee on Reports of Standing Committees recommended approval of this report.

The House adopted this recommendation of the Reference Committee.

(12) COMMITTEE ON CHILD WELFARE

The Reference Committee on Reports of Standing Committees approved this report, particularly commending an approach to the total health of the youth, rather than just physical health.

The House adopted the report of the Reference Committee.

(13) COMMITTEE ON DIABETES

The Reference Committee on Reports of Standing Committees approved this report.

The House adopted the report of the Reference Committee.

(14) COMMITTEE ON GERIATRICS

The Reference Committee on Reports of Standing Committees recommended that the report be filed and the Committee commended for its work.

The House adopted this recommendation of the Reference Committee.

(15) COMMITTEE ON HIGHWAY ACCIDENT PREVENTION

The Reference Committee on Reports of Standing Committees presented the following report:

"This Report recommended that the Michigan State Medical Society communicate with Michigan police chiefs and sheriffs, informing them that it is the considered viewpoint of Medicine that the Snellen Chart is the preferred tool for driver vision testing by lay personnel.

"The Committee also recommended that the Michigan State Medical Society reiterate its support for the passage by the State Legislature of the Uniform Vehicle Code provisions for the testing of intoxicated drivers, if such proposal is introduced during the 1963 Session."

The Reference Committee recommended approval of the report.

The House adopted this recommendation of the Reference Committee.

(16) COMMITTEE ON IODIZED SALT

The Reference Committee on Reports of Standing Committees recommended approval of the report.

The House adopted this recommendation of the Reference Committee.

(17) COMMITTEE ON MATERNAL HEALTH

The Reference Committee on Reports of Standing Committees commended the Committee and recommended acceptance of its report.

The House adopted this recommendation of the Reference Committee.

(18) COMMITTEE ON MENTAL HEALTH

The Reference Committee on Reports of Standing Committees presented the following report:

"This Committee made the following recommendations:

"1. That the Michigan State Medical Society and Mental Health Committee continue the progress in implementing the policies of the AMA Council on Mental Health and the AMA Congress on Mental Illness and Health.

"2. That the MSMS and Mental Health Committee study carefully, and be actively involved in, the development of community mental health services.

"3. That the Mental Health Committee follow closely the new developments in the Michigan Department of Mental Health.

"4. That the MSMS continue to actively support the Interstate Compact for Mental Health.

"5. That the MSMS be represented and actively involved in the statewide planning for mental health projects by the Michigan Department of Mental Health."

The Reference Committee recommended approval of these five recommendations.

The Reference Committee reported further that "a sixth recommendation: that the Michigan Department of Health continue to be an autonomous department in the forthcoming reorganization of the executive branch of the State Government of Michigan, as provided in the new Constitution for the State of Michigan, seemed inappropriate at this time."

The Reference Committee therefore recommended that the remainder of the annual report of the Committee on Mental Health be filed, and the Committee commended for its conscientious efforts.

The House adopted this report of the Reference Committee.

(19) COMMITTEE ON OCCUPATIONAL HEALTH

The Reference Committee on Reports of Standing Committees recommended that the report be filed and the Committee

commended for its work in behalf of the Michigan State Medical Society.

The House adopted the report of the Reference Committee, with an amendment substituting the words "reported without action" for the word "filed."

(20) COMMITTEE ON TUBERCULOSIS CONTROL

The Reference Committee on Reports of Standing Committees recommended approval of the report.

The House adopted this recommendation of the Reference Committee.

(21) COMMITTEE ON VENEREAL DISEASE CONTROL

The Reference Committee on Reports of Standing Committees recommended that the report be filed.

The House adopted this recommendation of the Reference Committee.

(22) COMMITTEE ON PUBLIC RELATIONS

The Reference Committee on Reports of Standing Committees recommended that every member of the Michigan State Medical Society read this report in detail and recognize the tremendous value to the State Society of the programming of this Committee. The Committee was commended for its outstanding work.

The House adopted the report of the Reference Committee.

(23) COMMITTEE ON SCIENTIFIC RADIO AND TELEVISION

The Reference Committee on Reports of Standing Committees extended appreciation to the Committee members and to the physicians who participated in the program.

The House adopted this report of the Reference Committee.

(24) COMMITTEE ON BLOOD BANKS

The Reference Committee recommended that this report be filed and that the Committee be commended for its work.

The House adopted this recommendation of the Reference Committee.

16. Reports of House of Delegates Committees

All of these reports have been printed in the Delegates' Handbook and/or THE JOURNAL.

(1) COMMITTEE ON CERTIFICATES OF COMMENDATION

The Committee submitted the names of the following members of MSMS for election to this Award: Forest D. Dodrill, M.D., Bloomfield Hills; Charles J. Jentgen, M.D., Detroit; John M. Sheldon, M.D., Ann Arbor; Homer Stryker, M.D., Kalamazoo. Abstracts of the attainments of the nominees were appended to the printed report for study by the delegates.

In order to expedite the preliminary work so these presentations could be made Tuesday night, September 24, the Committee requested that the House of Delegates suspend the rules and that the nominees be voted upon at that time.

The House adopted the report, the rules were suspended and the nominees were elected.

(2) CONSTITUTION AND BYLAWS COMMITTEE

The Reference Committee on Constitution and Bylaws, Ralph R. Cooper, M.D., Chairman, reported the following amended Resolution 3 of the 1962 House of Delegates:

Whereas, the Washtenaw County Medical Society has long been aware of the presence in the State of Michigan of many doctors of medicine in academic or industrial teaching, research or administration who do not hold a license to practice medicine in Michigan because they are not directly concerned with patient care, and

Whereas, the Washtenaw County Medical Society has received an opinion from the Legal Counsel of MSMS that election of such persons to active membership would be in violation of the Bylaws of the MSMS, and

Whereas, the Washtenaw County Medical Society believes that such persons should be granted active membership, rather than associate membership, which is essentially a temporary status (see Chap. 5, Sec. 3 (d)), and

Whereas, the Washtenaw County Medical Society believes that many of these persons would be happy to associate themselves on an equal basis with the local Society, and

Whereas, the Washtenaw County Medical Society believes that its members also would benefit from the association and experience of these persons, therefore be it

RESOLVED: That in order to accomplish these ends, the Constitution and Bylaws of MSMS be amended as follows:

(1) That Article VIII, Section 1 of the Constitution be amended to include, after the phrase "This Society shall consist of Active Members . . .", the words "non-licensed Members," and after the words "retired members," the words "Non-Resident Members." (This last is to correct a previous error).

(2) That Sect. 1 of Chap. 2 of the Bylaws be deleted, and that in its place the following be substituted:

Section 1. Active Members. Active Members of this Society shall comprise all the active members of the several component county societies. To be eligible for active membership in any component county society, a Doctor of Medicine must hold an unrevoked license to practice Medicine, Surgery and Mid-Wifery in Michigan or if unlicensed, must be engaged in academic teaching, research or administration, and comply with all the provisions of the Bylaws of this Society and the component county society.

(3) That to make room for a new Section 2 of Chapter 5, the sections presently numbered 2-9 inclusive be numbered 3-10 respectively, and a new section added as follows:

Section 2. Non-Licensed Members.—Component County Societies may elect to membership in this category Doctors of Medicine who are engaged in teaching, research, or administration, but are not directly concerned with the care of patients, and who do not hold a valid license to practice Medicine, Surgery and Mid-Wifery in Michigan by authority of the Michigan State Board of Registration in Medicine, but comply otherwise with all applicable provisions of these Bylaws. Such members shall be eligible to vote and hold office, and shall pay the same dues as Active Members.

(4) That present Sec. 3 (d) of Chapter 5 (New Section 4) be deleted. Be it further

RESOLVED: That the Michigan Delegates to the American Medical Association be instructed to prepare and introduce into the House of Delegates of the AMA a resolution seeking similar amendments to the Constitution and Bylaws of the AMA.

The Reference Committee recommended the adoption of the amended resolution, paragraph (1) being laid over until the next Annual Session, and paragraph (2) being laid over until the next meeting of this House.

At the next meeting, **The House** did adopt 1962 Resolution 3, as amended, with the exception of paragraph (1) which was laid over until the 1964 Annual Session.

(3) SUPPLEMENTAL REPORT OF STANDING COMMITTEE ON CONSTITUTION AND BYLAWS

The Committee presented the following report on 1962 House of Delegates Resolutions 13 and 15, entitled "Mediation Committee" and "Disciplinary Procedures," and the revision and simplification of Chapters 6 and 7 of the Bylaws as submitted by MSMS Legal Counsel, Mr. Lester P. Dodd. The revised chapters are as follows:

CHAPTER 6—CONDUCT AND DISCIPLINE OF MEMBERS

THIS COMBINES AND SHORTENS PRESENT SEC. 1 & SEC. 2

Sec. 1—*STANDARDS OF CONDUCT—GROUND FOR DISCIPLINE*—Any conduct of a member of this or any component County Society, whether or not occuring in the course of a physician-patient relationship, which

(a) is in violation of the Principles of Medical Ethics of the American Medical Association, or

(b) constitutes unprofessional and dishonest conduct as defined by Act 237 of the Public Acts of Michigan of 1899, as amended or

(c) results in conviction of a felony under the laws of any state or of the United States of America, or

(d) results in revocation or suspension of the member's license to practice medicine, or

(e) is in violation or disregard of the constitution, by-laws, principles, rules, regulations or orders of this Society or of the American Medical Association, or

(f) constitutes defamation or otherwise unjust reflection on the integrity, character or professional performance or reputation of a fellow member of the profession, or

(g) is prejudicial to or tends to expose the medical profession or this or a component County Society to contempt or reproach, or which is in anywise contrary to ethics, honesty or good morals,

shall be ground for discipline. The willfull failure or refusal of a member whose conduct has been called into question to appear before an Ethics Committee upon request or to cooperate with such Committee in its authorized investigation shall also, in and of itself, be ground for discipline.

SHORTENS PRESENT SEC. 3

Sec. 2 —*DISCIPLINE—WHAT CONSTITUTES*—Discipline as used in this Chapter shall include reprimand, suspension and expulsion.

FROM PRESENT SEC. 4

Sec. 3—*DISCIPLINE—WHAT PROCEDURE TO GOVERN*—All disciplinary proceedings shall be governed by the provisions of this Chapter, any provisions of the Constitution or By-Laws of any component County Society to the contrary notwithstanding.

FROM PRESENT SEC. 4

Sec. 4—*SOCIETY OF MORE THAN 150 MEMBERS*—Any component County Society having more than one hundred fifty active members may, by appropriate provisions in its Constitution or By-Laws, delegate its authority and power to discipline its members to the governing board of such Society, in which event, all of the functions, powers and duties of a component County Society as set forth in this Chapter shall be exercised and carried out by such governing board. Unless otherwise provided by the Constitution or By-Laws of such component County Society, any order of expulsion or suspension made by such governing board shall be subject to the approval of the component County Society in the same manner as may be provided for the approval of any other report of such governing board.

PRESENT SEC. 5 WITH UNNECESSARY LANGUAGE ELIMINATED

Sec. 5—*ETHICS COMMITTEE*—Every component County Society shall have a standing committee designated the Ethics Committee, charged with duties and powers concerning the maintenance of standards of conduct and discipline of members, including the duties and powers specifically set forth in this chapter.

PART OF PRESENT SEC. 6 MADE MORE CONCISE

Sec. 6—*REQUEST FOR INVESTIGATION*—Upon the receipt by a component County Society of a writteen request for investigation of the conduct of one of its members, signed by an active member or committee of such component County Society and setting forth briefly the alleged facts of such claimed misconduct, such request for investigation shall be referred to the Ethics Committee.

THIS IS AN EFFORT TO GIVE COUNTY SOCIETY MORE LEEWAY AND LESS FORMALITY

Sec. 7—*INFORMAL INVESTIGATION—PROCEDURE*—The Ethics Committee shall thereupon make such informal investigations as the circumstances and nature of the matter require. The procedure to be followed shall be determined by the Ethics Committee but shall be such as to insure that the member whose conduct is questioned has full opportunity to be heard and to offer any defense or explanation available to him.

THESE SECTIONS ARE PRESENT SEC. 7 MADE MORE CONCISE

Sec. 8—*INFORMAL INVESTIGATION—DISMISSAL*—Upon conclusion of its informal investigation the Ethics Committee, shall, if it decides that there is no ground for discipline, dismiss the matter and so report to the Society.

Sec. 9—*INFORMAL INVESTIGATION—REPRIMAND*—If, upon the conclusion of its informal investigation, the Ethics Committee decides that the member whose conduct is questioned is guilty of conduct warranting only a reprimand it shall forthwith administer such reprimand and so report to the Society unless a formal hearing is demanded by the member.

THIS IS PRESENT SEC. 8 AS SHORTENED

Sec. 10—*FORMAL COMPLAINT—NOTICE OF HEARING*—If the Ethics Committee finds there is reasonable cause to believe that the respondent is guilty of misconduct warranting suspension or expulsion from membership, or if the respondent demands a formal hearing, a formal complaint setting forth the facts of the alleged misconduct shall be prepared by the Ethics Committee and subscribed by the Chairman or Vice-Chairman thereof. A copy of such complaint shall be filed with the component County Society. Thereupon, it shall be the duty of the Ethics Committee or its Chairman to fix the time and place for a formal hearing thereon. A written notice of such hearing, together with a copy of the formal complaint, shall be served on the respondent by registered or certified mail not less than thirty days before the date of such hearing.

THIS IS FIRST HALF OF PRESENT SEC. 9

Sec. 11—*ANSWER TO FORMAL COMPLAINT*—It shall be the duty of the respondent to file an answer to the formal complaint. Such answer shall be in writing, signed by the respondent, and filed with The Ethics Committee within fifteen days after service of the copy of formal complaint. The answer shall admit or deny each material allegation contained in the complaint, and shall set forth any special defenses which the respondent claims to have. If the answer is not filed within the time hereby limited, the complaint may be taken as confessed.

THIS IS THE SECOND HALF OF PRESENT SEC. 9 WITH THE IMPORTANT ADDITION OF RIGHT TO COUNSEL

Sec. 12—*FORMAL HEARING—HOW CONDUCTED—RIGHT TO COUNSEL*—It shall be the duty of the respondent to appear before the Ethics Committee in person at the time and place specified in such notice. Both the respondent and the Ethics Committee shall be entitled to be represented by counsel at such hearing. At such formal hearing, it shall be the duty of the respondent to answer fully and fairly all questions pertaining to his conduct which may be put to him by any member of the Committee of the component County Society or its counsel. Formal hearings shall be conducted fairly, but not necessarily in accordance with all rules governing court trials. A stenographic record shall be made of the proceedings at such hearings.

Sec. 13—*FINDINGS AND REPORT—(present Sec. 10—unchanged)*

Sec. 14—*ACTION ON REPORT—ADDITIONAL TESTIMONY—(present Sec. 11—unchanged)*

Sec. 15—*ACTION BY SOCIETY—(present Sec. 12—unchanged)*

Sec. 16—*FINALITY AND EFFECTIVENESS OF ORDER —(present Sec. 13—unchanged)*
Sec. 17—*APPEAL PROCEDURE—(present Sec. 14—unchanged)*
Sec. 18—*APPEAL TO JUDICIAL COUNCIL OF AMERICAN MEDICAL ASSOCIATION—(present Sec. 15—unchanged)*
Sec. 19—*EXCEPTION TO PROCEDURES—(present Sec. 16—unchanged)*
Sec. 20—*EFFECT OF SUSPENSION OR EXPULSION—(present Sec. 17—unchanged)*
Sec. 21—*CONSTRUCTION—(present Sec. 18—unchanged)*

CHAPTER 7—GRIEVANCES OF NON-MEMBERS—MEDIATION

THIS ELIMINATES UNNECESSARY DECLARATION OF POLICY

Sec. 1—*MEDIATION COMMITTEE*—Every component County Society shall have a standing Committee designated the Mediation Committee. The Councilors of the respective districts of the Society within which a component County Society is situated shall be eligible to membership on such Committee.

THIS IS PRESENT SEC. 2 UNCHANGED

Sec. 2—*PURPOSES*—The purposes of such committee shall be:

(a) To afford the public an informal means of making known to the profession any alleged grievance arising from a physician-patient relationship;
(b) To resolve misunderstanding between physician and patient or between component County Society and the public;
(c) To reconcile differences between physician and patient by means of persuasion and explanation; and
(d) To assist the Ethics Committee of its component County Society in maintaining among members high levels of professional deportment.

THIS ELIMINATES THE SPECIFIC DUTIES TO WHICH SOME COUNTY SOCIETIES SEEM TO OBJECT AND ALLOWS THE FUNCTIONING OF SUCH A COMMITTEE TO BE AS FLEXIBLE AS THE COUNTY SOCIETY WANTS TO MAKE IT

Sec. 3—*POWERS AND DUTIES—LIMITATION*—The specific powers and duties to be exercised by such committee in furthering the purposes above set forth, shall be as fixed and determined by the component County Society, provided, however, that such committee shall function in the area of mediation or conciliation only and shall not have power to act as a trial body or to render decisions or awards, nor shall such committee have power to impose discipline or in anywise encroach upon the function of the Ethics Committee.

The Reference Committee on Constitution and Bylaws, R. R. Cooper, M.D., Chairman, recommended approval of the report as corrected above. The proposed Bylaws changes were then laid over until the next meeting of the House.

The House, at its next meeting, adopted the recommendations of the Reference Committee and these changes became part of the Bylaws.

(4) COMMITTEE TO STUDY EMERGENCY CARE IN HOSPITALS

The Reference Committee on Emergency Medical Service, M. L. Lichter, M.D., Chairman, presented the following report:

"We wish to commend this Committee, whose Chairman is Dr. John G. Slevin, for a most excellent report, well documented with data which has heretofore not been available.

"Section A would have no change.

"Section B would read: 'That practicing physicians be encouraged to personally render emergency care to their patients when needed.'

"Paragraph C has been modified: 'That the Michigan State Medical Society urge the medical staff of Michigan hospitals to be guided by the following points:

'1. Attempt to limit services in the emergency room to those situations which in the best judgment of the medical staff qualify as emergency.

'2. When a patient presents himself at the emergency room, reasonable effort should be made to notify the patient's physician and, whenever conditions permit, the physician should render the necessary care to his patient.

'3. The medical staff should develop rules and regulations concerning the supervision of emergency room service performed by interns and residents as part of their training program.

'4. All compensation for professional services shall be paid directly to the physician and not to any intermediary.

'5. The bylaws of the medical staff of a hospital should clearly spell out the responsibilities of the staff in connection with the emergency room.'

"Recommendation D has been modified and would read as follows:

'D. That Michigan Hospital Service be urged to modify or withdraw its present extensive hospital out-patient contract coverage. It is to be pointed out that data in an addendum to this report demonstrates a sudden sharp increase, which has continued, in hospital out-patient utilization following the Blue Cross offering of such benefits in October 1957. It is the Committee's belief that it is an important factor in the general rise in emergency room utilization.'

"Paragraph E was deleted by the Reference Committee.

"Paragraph F then becomes paragraph E. The present paragraph F is slightly modified as follows: 'E. That a copy of this report in its entirety be sent to the chief of staff of each Michigan hospital as well as to the Michigan Hospital Association, Michigan Hospital Service, and Michigan Medical Service; and that an abstract of the report be included in the County Society Letter.'

"On page 4 of the report as submitted, your Reference Committee recommends a change in the sixth line from the bottom of the page. This sentence would read: 'Adoption by medical staffs of hospitals in Michigan of the standards for the emergency department in hospitals formulated by the American College of Surgeons would establish high standards for such service.'

"One of the addenda to the annual report is a memorandum from the Chairman concerning a personal meeting which he had during the course of the session. Your Reference Committee regards this most highly, but feels that since it is for information it should not be part of the permanent report of the Study Committee, and therefore your Reference Committee recommends its deletion from the final report.

"We commend the statistical data in this report to the careful perusal of each member of the House of Delegates as well as any person interested in this subject.

"Of particular note is the result of a survey of twenty-one hospitals, of whom nineteen responded. This is contained in the supplemental annual report of the House of Delegates Committee to Study Emergency Care in Hospitals. To the best of our knowledge, such a survey has not been carried out before. All those concerned with this development are to be highly congratulated. Examination of this material will be most revealing, and the Reference Committee feels that the House of Delegates Committee cannot be congratulated too highly for having done this very excellent piece of original work.

"One other addendum to the annual report is entitled, 'Standards for Emergency Department in Hospitals,' which was developed by the American College of Surgeons. Your Reference Committee recommends that this document can be profitably used by the medical staff of a hospital as a guideline.

"Your Reference Committee recommends that the Committee to Study Emergency Care in Hospitals be continued so that the House of Delegates can be periodically apprised of activity in this important area."

The Reference Committee recommended approval of the Annual and Supplemental Reports as amended.

The House adopted the recommendation of the Reference Committee.

(5) COMMITTEE TO STUDY HONORARIUM FOR MSMS OFFICERS

The Reference Committee on Ways and and Means, N. L. Avery, M.D., Chairman, presented the following report:

"The Report was approved in principle, namely, that it would be desirable, under certain circumstances, to give honoraria to MSMS officers, but it was referred back to The Council for further study and a later report to the House of Delegates. A well-deserved commendation was expressed for the very considerable amount of effort put into this proposal by Robert M. Stow, M.D., and the other members of the Committee and Mr. Ben P. Stratton, our insurance adviser."

The Reference Committee recommended approval of the report.

The House adopted the report of the Reference Committee.

(6) COMMITTEE TO STUDY MSMS FINANCIAL STRUCTURE

The Reference Committee on Special Committees, John G. Slevin, M.D., Chairman, presented the following report:

"The report was carefully reviewed. It was noted that the Committee observed that $15 of the present dues is allocated to maintaining and defraying the debt on the headquarters building. This item was discussed by your Reference Committee.

"It was also noted and discussed that the report commends The Council and its Finance Chairman for the manner in which the headquarters building has been financed, with an annual saving of $4,000 in interest rates. Your Reference Committee concurs in this commendation.

"The Reference Committee noted and inquired into the loss reported on page 8 of $21,542 and learned that this is largely a 'paper loss' due to building depreciation and the payments on the Michigan State Medical Society's debts of $50,000.

"The Reference Committee took cognizance of that part of the report concerned with the Department of Socio-Economics, and observed that the $5 dues allocated to this Department resulted in income of $29,650 and expenditure of $20,534. The Reference Committee concurs in the report that this money is well spent.

"The Reference Committee calls attention to that part of the report on page 13 concerned with the Michigan Clinical Institute and to the declining attendance at the Michigan Clinical Institute. The report recommends that The Council re-evaluate MCI as a teaching refresher course. Your Reference Committee concurs in this recommendation.

"Your Reference Committee recommends only two minor changes in the report, in both of which Dr. H. W. Harris, Chairman of this Study Committee, concurs:

1. On Page 14, item 5, after 'present dues,' there be inserted the words 'of $80 per year.'
2. The striking out of the 'special note' on page 15 which, we are informed, is no longer germane.

The Reference Committee recommended approval of the report as amended.

The House adopted the report of the Reference Committee.

(7) COMMITTEE TO STUDY RELATIONSHIP BETWEEN DOCTORS OF MEDICINE AND DOCTORS OF OSTEOPATHY

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman, presented the following report:

"It is recommended that the word 'Chairman' be changed to 'Speaker' in the last sentence of paragraph 1.

"Recommendation No. 1: Add the word 'for' after 'respect' in line 2, and change 'cooperation for' to 'cooperation with' also in line 2, so that Recommendation No. 1 will read:

'That the Michigan State Medical Society affirm a policy of professional respect for and cooperation with the Society of Michigan Osteopathic Physicians and Surgeons in those areas of common responsibility and common interest where such cooperation can be of benefit to the people of Michigan.'

'Recommendation No. 2: That the MSMS House of Delegates' Committee to Study Relationship Between Doctors of Medicine and Doctors of Osteopathy be continued, with members serving one, two, or three-year overlapping terms with sufficient carry-over each year to assure continuity of this study, inasmuch as it is felt that the situation will continue in a state of change, making it desirable that there be continuity of knowledge of this Committee.'

"The Reference Committee recommended approval of Recommendation No. 2."

"The Reference Committee reviewed Recommendations Nos. 3 through 7 jointly. These are:

'Recommendation No. 3: That such a Committee be authorized to explore the ramifications under the new State Constitution relative to licensure and licensing boards.'

"Recommendation No. 4: That the need for much additional information concerning the scientific training and ethical backgrounds of the doctors of osteopathy and the doctors of medicine be recognized, and that an exchange of information upon high levels be sought between the respective official organizations and their representative medical colleagues.

"Recommendation No. 5: That there is need to obtain information from the other 49 states concerning the status of former graduates of the California College of Medicine, and that we consider the possible desirability of suggesting to the Michigan State Board of Registration in Medicine a review of its decisions relative to licensure of former graduates of the California Medical College (previously the California Osteopathic College).

"Recommendation No. 6: That MSMS recognize the need to continue to study and to explore all the aspects of joint hospital staffs and hospital accrediting requirements where doctors of osteopathy and doctors of medicine practice together. This may continue to be of ever-increasing importance in smaller communities where joint staffs will work in community hospitals.

"Recommendation No. 7: That MSMS authorize the Committee to study the feasibility of accepting graduates of recognized osteopathic medical colleges for internships and residencies at doctor of medicine hospitals.

"The Reference Committee approved Recommendations Nos. 3 through 7 as information for the Committee appointed in Recommendation No. 2."

"Recommendation No. 8: That the Michigan State Medical Society welcome to its postgraduate scientific programs doctors of osteopathy.

"Your Reference Committee recommends that Recommendation No. 8 be disapproved."

"Recommendation No. 9: The Reference Committee recommends changing the last word from 'D.O.s' to 'Doctors of Osteopathy' so that it will read:

"That the MSMS suggests to component County Societies that where possible they explore the desirability of establishing a local liaison committee with doctors of osteopathy."

The Reference Committee recommended approval of the report as amended.

The House adopted the report of the Reference Committee.

RESOLUTIONS

No. 1—Instruction on External Cardiac Massage

Introduced by G. A. Drake, M.D., Northern Michigan

Whereas, external cardiac massage is an important adjunct to emergency care of some patients; and

Whereas, proper instruction of physicians, paramedical personnel, rescue squads, ambulance squads and others dealing with emergency care is necessary and desirable; therefore be it

RESOLVED: That each county medical society make available a source of competent instruction in external cardiac massage to all eligible persons in its area in cooperation with the American Heart Association.

The Reference Committee on Hygiene and Public Health, E. M. Vardon, M.D., Chairman, recommended that the last seven words of the resolution be stricken and that the resolution be approved as amended.

The House adopted this recommendation of the Reference Committee.

Resolutions Nos. 2, 35, 41, 57 and 58 were considered together by the Reference Committee on Legislation and Public Relations.

No. 2—Michigan Crippled Children Commission's Regulations

Introduced by J. P. Klein, M.D., Newaygo

Whereas, the continued promulgation of regulations attempts to control the practice of medicine on afflicted and crippled children by the Michigan Crippled Children Commission and its Director without accomplishing any purpose whatsoever except to promote socialized medicine and enhance the powers of the Commission; and

Whereas, the patients under the control of the Commission have lost their free choice of physician; and

Whereas, the chronic shortage of funds provided by the Legislature cannot be solved by fantastic regulations of said Commission; therefore be it

RESOLVED: That the Michigan Crippled Children Commission be abolished and its work be returned to the respective county welfare boards who by their direct contact will be able to process all cases better and more economically.

No. 35—Determination of Qualifications for Physicians Performing Services for Michigan Crippled Children Commission

Introduced by V. V. Bass, M.D., Saginaw

Whereas, a recent ruling of the Michigan Crippled Children Commission designated that only certain specialists be allowed to perform certain procedures; and

Whereas, such a ruling is in opposition to the time honored patient-physician relationship; and

Whereas, every approved hospital through its local accreditation mechanism, sets policies; therefore be it

RESOLVED: That any physician that is deemed qualified to perform a procedure in his local area by the staff of an approved hospital be deemed qualified to perform such a procedure of the Michigan Crippled Children Commission.

No. 41—Michigan Crippled Children Commission

Introduced by Robert M. Leitch, M.D., Branch

Whereas, the Michigan Crippled Children Commission has limited elective surgical procedures to board diplomates or imposed unnecessary consultation restrictions to the interest of economy; and

Whereas, there are many areas in the State remote from said board diplomates, making these services uneconomical both of time and money; and

Whereas, many of these elective procedures can best be performed in the patient's local hospital, thus guaranteeing free choice of physician and maintaining a better physician-patient relationship; therefore be it

RESOLVED: That the MSMS advise the MCCC of its disapproval of this edict and encourage the MCCC to return elective procedures to their proper place; and be it further

RESOLVED: That the MSMS advise its own membership of the limited funds of the MCCC and encourage the membership to limit requests of MCCC to the barest minimum; and to seek funds elsewhere, e.g., County Welfare Agencies, Service Club funds, etc., when available.

No. 57—Administration of Michigan Crippled Children Commission

Introduced by H. G. Bacon, M.D., Mason

Whereas, the surgery regulations of the Michigan Crippled Children Commission are impractical in many instances, and are discriminatory; and

Whereas, the 30-day limitation of payments is too short, and the billing and application forms are unnecessarily complicated; and

Whereas, the fee schedule of the MCCC is antiquated and far below the Michigan Uniform Fee Schedule; and

Whereas, the local administration of the MCCC could be more efficiently and more economically handled by local welfare departments; and

Whereas, the financial appropriations of the State Legislature for the MCCC are inadequate for proper administration; therefore be it

RESOLVED: That the Michigan State Medical Society thoroughly investigate the MCCC, ts functions and its policies; and be it further

RESOLVED: That MSMS take any necessary action to correct these deficiencies and injustices; and be it further

RESOLVED: That, should the above corrections not be effected, the MCCC be eliminated, and its functions taken over by the local welfare departments.

No. 58—Abolishment of Michigan Crippled Children Commission

Introduced by Louis F. Hayes, M.D., North Central Counties

Whereas, the Michigan Crippled Children Commission was originally established to administer private money that is the Couzens' Fund; and

Whereas, since the exhaustion of these funds, this Commission has subsisted on state money in parallel with other bureaus administering public funds for welfare purposes; and

Whereas, these funds can be administered and services supplied by already existing State Welfare Bureaus; and

Whereas, unnecessary costs are entailed in maintaining an extra bureau with subsequent personnel and expenditure; be it therefore

RESOLVED: That the Medical Society of the North Central Counties introduce a resolution in the House of Delegates of the Michigan State Medical Society favoring a recommendation to the Legislature to abolish this unnecessary bureau.

The Reference Committee on Legislation and Public Relations, L. A. Drolett, M.D., Chairman, presented the following report:

"We have met with Donald Smith, M.D., Acting Director of the Michigan Crippled Children Commission; Mr. Thomas Lindsay, Assistant Director; Clifford Brainard, M.D., Hospital Field Representative, and discussed various phases of Michigan Crippled Children Commission activities, and we deem it unadvisable at this time to adopt these resolutions because of several factors:

1—Lack of understanding of the reasoning behind some of the recent Commission rulings.

2—Restriction of funds appropriated by the Legislature for the afflicted children's program.

3—Lack of liaison in prior years between the Commission and the doctors.

"The Reference Committee recognizes the value of the Michigan Crippled Children Commission in giving support and services for handicapped children in the State over the years. The success of this has been dependent upon the cooperation and support of physicians in Michigan.

"As a result of our discussion here, the Reference Committee believes that improved liaison between practicing physicians and the Commission can be worked out successfully, and that this would be important to the future success of the program of the Michigan Crippled Children Commission.

"The Acting Director of the Michigan Crippled Children Commission assured the Committee that all efforts are being taken to establish a physician-patient relationship in the care of certain elective procedures under the afflicted children's program. His recommendations to the Michigan Crippled Children Commission are to be that the Commission utilize hospital credential committees of individual hospitals throughout the State to determine qualifications for a physician to perform these elective procedures; that a list of the credential committees with men recognized be filed with the Commission; that doctors as certified need not be Board-certified doctors, and consultations from the approving doctors will be paid for by the Commission.

"The Director stated that fees paid by the Michigan Crippled Children Commission have been raised from 66 to 80 per cent of the hospital billing and that efforts are now being made, with the approval of the Legislature, to bring doctors' fees up to date. The Director further feels confident that this will be accomplished within the next year. The Director also assured all that steps are being taken to simplify the billing procedures, and that the time factor has been extended to 45 days.

"The Committee felt that a better liaison has been established by our deliberations, and the Medical Director agreed that

he was pleased that this had been accomplished. The Committee feels that the air has been cleared of some misunderstandings and doubts regarding procedures, and definite steps forward have been made in establishing a better liaison with the Michigan Crippled Children Commission. With this in mind, the Committee herewith offers a substitute resolution in lieu of Resolutions Nos. 2, 35, 41, 57, 58:

Substitute Resolution

Whereas, recent ruling of the Michigan Crippled Children Commission designated that only Board-certified specialists be allowed to perform certain elective procedures; and

Whereas, such a ruling is in opposition to the time-honored patient-physician relationship; and

Whereas, we have received assurance from the Director of the Michigan Crippled Children Commission that they will look favorably on our recommendations in this regard; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society recommend to the Michigan Crippled Children Commission:

1—That the Commission utilize the services of the hospital credential committee in determining the qualifications for any elective surgery done under the Afflicted Children's Program.

2—That the Michigan Crippled Children Commission take steps to simplify its billing procedures.

3—That the Michigan Crippled Children Commission continue its efforts to revise its fee schedule and bring it up to date.

4—That The Council of the Michigan State Medical Society establish a liaison committee with the Michigan Crippled Children Commission."

The Reference Committee recommended approval of the substitute resolution.

The House adopted the recommendation of the Reference Committee.

No. 3—Formation of State Medical Disciplinary Board

Introduced by Gregory P. Moore, M.D., Wexford-Missaukee

Whereas, certain matters involving the conduct of physicians in the State of Michigan in such problems as professional misconduct, misuse of narcotics, and mental disorders, cannot be adequately and properly and safely investigated under the jurisdiction of any medical agency or under the provisions governing the Board of Medical Registration; and

Whereas, several cases which might well have been handled more efficiently have presented themselves during the past few years; and

Whereas, the individual physician may render himself liable to lawsuits in the event of initiating measures against colleagues despite almost certain wrongful actions under present legal interpretation; and

Whereas, at least one of the States has had functioning for several years a State Medical Disciplinary Board created by act of the Legislature, elected by the members of the State Medical Society, enjoying legal immunity, and so provided for that adequate and timely investigations and actions can be accomplished; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society request The Council of the Michigan State Medical Society to investigate the problems involved and make recommendations for action toward legislation leading to the formation of a State Medical Disciplinary Board or similar body.

The Reference Committee on Legislation and Public Relations, L. A. Drolett, M.D., Chairman, recommended that the last three words of the Resolved be stricken and words "composed of qualified doctors of medicine whose names have been approved by The Council" be added, and that the resolution as amended be approved.

The House adopted an amendment to the Reference Committee report deleting the last three words of the Resolved and adding "composed of qualified doctors of medicine elected by the House of Delegates of the Michigan State Medical Society."

The House adopted the resolution as amended by the House.

Resolutions Nos. 4 and 62 were considered together by the Refcrence Committee on Constitution and Bylaws.

No. 4—Change name of Section on Nervous and Mental Diseases

Introduced by Clifford W. Colwell, M.D., Genesee

Whereas, the Section name "Nervous and Mental Diseases" is not in accordance with modern-day terminology; therefore be it

RESOLVED: That the name of the "Section of Nervous and Mental Diseases" of the Michigan State Medical Society be changed to that of the "Section of Psychiatry and Neurology" which would also be in accordance with the nomenclature of the Michigan Society of Psychiatry and Neurology.

No. 62—Representation of Specialty Sections by Authorized Election of Specialty Delegates to the House of Delegates of MSMS

Introduced by H. F. Falls, M.D., Washtenaw

Whereas, there is a steady geometric and persistent increase in the practice of modern medicine; and

Whereas, the health and socio-economic problems of such specialty groups are unique and specialized; and

Whereas, the deliberations of this House of Delegates necessitate the informed opinions of these specialty groups; and

Whereas, the MSMS House of Delegates does presently not provide representation for such specialties; therefore be it

RESOLVED: That the House of Delegates take cognizance of this deficiency of representation; and be it further

RESOLVED: That the House of Delegates authorize the election of a delegate from each of the presently authorized and established specialty sections of MSMS.

The Reference Committee on Constitution and Bylaws, R. R. Cooper, M.D., Chairman, presented the following report:

We find much merit in the two resolutions, but we feel that they cannot be acted upon until a special study in depth of the whole section structure is made, including definition of the qualifications for membership in the diverse sections.

"Therefore, the Committee recommends that an Ad Hoc Committee of the House be appointed by the Speaker to study in depth the structure of the sections of the MSMS, the qualifications for section membership, and the question of section representation in the House of Delegates of MSMS."

The House adopted this recommendation of the Reference Committee.

No. 5—Social Security Coverage for Physicians

Introduced by H. C. Rees, M.D., Wayne

Whereas, the members of the Michigan State Medical Society have gone on record by a vote if 3,099 to 1,845 in favor of compulsory social security for physicians; therefore be it

RESOLVED: That the Michigan Delegates to the House of Delegates of the American Medical Association be instructed to introduce and support a resolution at the 1963 Interim Session of the American Medical Association House of Delegates recommending the inclusion of physicians under Social Security.

The Reference Committee on Resolutions, R. E. Wunsch, M.D., Chairman, recommended that the Resolved be amended by substituting the word "a" for the words "the 1963 Interim."

The House amended the report by substituting "next" for "a."

The House adopted the report of the Reference Committee as amended by the House.

Resolutions Nos. 6 and 64 were considered together by the Reference Committee on Legislation and Public Relations.

No. 6—Single Medical Practice Act

Introduced by J. B. Blodgett, M.D., Wayne

Whereas, Doctors of Osteopathy are granted an unlimited license to practice medicine, surgery, obstetrics and all other branches of the healing art on the same basis as Doctors of Medicine (Public Act No. 162 of 1903); and

Whereas, Michigan now has more licensed osteopathic phy-

sicians than any other state and the number is steadily increasing; and

Whereas, the 1962 House of Delegates approved the principle of a single medical practice law to govern the licensing of all who seek to practice the healing art in Michigan; therefore be it

RESOLVED: That this House of Delegates reaffirm its endorsement of a single medical practice law; and be it further

RESOLVED: That the Michigan State Medical Society urge the State Legislature to adopt such legislation.

No. 64—Single Medical Practice Act

Introduced by J. D. Fryfogle, M.D., Wayne

Whereas, Doctors of Osteopathy are granted an unlimited license to practice medicine, surgery, obstetrics and all other branches of the healing art on the same basis as Doctors of Medicine (Public Act No. 162 of 1903); and

Whereas, Michigan now has more licensed osteopathic physicians than any other state and the number is steadily increasing; and

Whereas, the 1962 House of Delegates approved the principle of a single medical practice law to govern the licensing of all who seek to practice the healing art in Michigan; therefore be it

RESOLVED: That this House of Delegates reaffirm its endorsement of a single medical practice law; and be it further

RESOLVED: That the Michigan State Medical Society urge the State Legislature to adopt such legislation.

The Reference Committee on Legislation and Public Relations, L. A. Drolett, M.D., Chairman, recommended that inasmuch as this action was adopted by the 1962 House and the Legal Affairs Committee has not had proper time to implement it and is still studying it, both of these resolutions be referred back to The Council for further study by the Legal Affairs Committee, and for appropriate action.

The House adopted the report of the Reference Committee.

No. 7—Government Subsidy of Prepaid Health Insurance for the Needy

Introduced by R. R. Cooper, M.D., Wayne

Whereas, the 1962 House of Delegates of the Michigan State Medical Society approved the principle of a tax credit and/or partial government subsidy of prepaid health insurance for the needy; therefore be it

RESOLVED: That the Michigan Delegates to the House of Delegates of the American Medical Association be directed to introduce and support a resolution at the 1963 Interim Session of the House of Delegates of the American Medical Association recommending approval of the above principle and its implementation through appropriate Federal legislation.

The Reference Committee on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, recommended to change the word "directed" to "advise" and add "if feasible" after the word "support" and that the resolution as amended be approved.

The House adopted the recommendation of the Reference Committee.

Resolutions Nos. 8 and 42 were considered together by the Reference Committee on Miscellaneous Business.

No. 8—Ethical Relationship of Doctors of Medicine and Doctors of Osteopathy in Michigan

Introduced by W. L. Brosius, M.D., Wayne

Whereas, since the American Medical Association House of Delegates in June, 1961, adopted a new statement on the ethical relationship between doctors of medicine and doctors of osteopathy which stated:

> "(1) It shall not be considered in itself unethical for members of the American Medical Association to associate professionally and on a voluntary basis with doctors of osteopathy who base their practice on the same scientific and ethical principles as doctors of medicine; and
>
> "(2) It is the prerogative and the obligation of each constituent medical association to implement this policy on a state or local basis.";

therefore be it

RESOLVED: That it shall not be considered unethical for members of the Michigan State Medical Society to associate professionally and on a voluntary basis with doctors of osteopathy who base their practice on the same scientific and ethical principles as doctors of medicine.

No. 42—Relationships between doctors of medicine and doctors of osteopathy

Introduced by B. P. Brown, M.D., Eaton

Whereas, the Board of Commissioners of the Joint Commission on Accreditation of Hospitals, Bulletin No. 25, states: (1) "Only doctors of medicine or doctors of osteopathy shall practice in hospitals listed by the American Hospital Association. (2) "If doctors of osteopathy are practicing in the hospital, then, under the requirements for listing, the overall supervision of clinical work must be under a doctor of medicine (as chief of staff and chief of department, if departmentalized)"; and

Whereas, the Michigan State Plan for Hospital and Medical Facilities construction for 1961-1962—Supplement (Hill-Burton) states; Section V, Paragraph 3: "The State Agency does not believe the difference in composition of staff is sufficient to justify programming of separate facilities for patients of medical and osteopathic physicians in communities which could not otherwise justify the existence of two separate hospitals, recognizing that any decision with respect to physician staff privileges is the prerogative of the local community."; and

Whereas, the University of Michigan Study on Hospitals and Medical Economics (The McNerney Report) points out methods by which health care of the people of Michigan could be improved by better coordination between doctors of medicine and doctors of osteopathy; and

Whereas, the Governor's Commission on Prepaid Hospital and Medical Care Plans (The Bowles' Report) recommends that the appropriate State Medical and Osteopathic Societies promptly take all measures necessary to permit hospitals to consider joint osteopathic and medical staffs; and

Whereas, separate hospitals for doctors of medicine and doctors of osteopathy are an uneconomical addition to the overall cost of medical care to the public; and

Whereas, there are now hospitals in Michigan with doctors of medicine and doctors of osteopathy on their staffs with approval of their respective county medical societies; therefore be it

RESOLVED: That it shall not be considered of itself unethical to admit doctors of osteopathy who base their practice on the same scientific and ethical principles as doctors of medicine to staff membership in hospitals in Michigan accredited by the Joint Commission on the Accreditation of Hospitals of the American Medical Association in the same manner and subject to the same regulations as doctors of medicine when the county medical society in which the hospital is located gives its approval.

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman, recommended that Resolution No. 8 be approved and Resolution No. 42 be disapproved since the intent of latter is included in Resolution No. 8.

The House adopted the recommendation of the Reference Committee.

No. 9—Michigan Medical Service and Doctors of Osteopathy

Introduced by A. H. Price, M.D., Wayne

Whereas, on January 9, 1963, the Board of Directors of Michigan Medical Service recommended to the members of the Corporation that doctors of osteopathy be represented on the Board of Directors of Michigan Medical Service; therefore be it

RESOLVED: That the Articles of Incorporation, Article 5, be amended to allow the members of the Corporation to give representation to doctors of osteopathy on the Board of Directors of Michigan Medical Service.

The Reference Committee on Medical Service and Prepay-

ment Insurance, J. B. Blodgett, M.D., Chairman, recommended no action on this resolution because the matter was now before the corporate body of Michigan Medical Service.

The House adopted the recommendation of the Reference Committee.

No. 10—Special Assessment

Introduced by L. J. Bailey, M.D., Wayne

Whereas, membership dues are to finance projects and expenses for the normal operation of the Society; and

Whereas, dues continue from year to year without specific action of the House of Delegates; and

Whereas, requests for additional monies for special projects and expenses not included in the budget should be clearly explained to the membership; and

Whereas, such special funds should be ear-marked and used only for the purpose designated; and

Whereas, the one-time $10 assessment authorized by the 1962 House of Delegates for the American Medical Association and Research Foundation was listed on the 1963 Membership Statement as dues and the reason for this increase in dues explained only on an enclosure; and

Whereas, many questions and complaints have arisen about this $10 increase in dues; therefore be it

RESOLVED: That requests to the membership for additional contributions to finance projects and expenses not included in the normal operations of the Society be not included as dues but listed on the Membership Statement as a Special Assessment; and be it further

RESOLVED: That the purpose and the duration of the Special Assessment be designated on the Membership Statement.

The Reference Committee on Resolutions, R. E. Wunsch, M.D., Chairman, recommended disapproval of the resolution after consideration that full and sufficient information is available to the entire membership of MSMS in the Journal and that enclosures have been made with dues statements explaining any current increase. Furthermore, no change in dues is possible without specific action of the House of Delegates.

The House did not adopt the recommendation of the Reference Committee. The House adopted Resolution No. 10.

No. 11—County Society Mental Health Committees

Introduced by E. H. Rodda, M.D., Bay-Arenac-Iosco

Whereas, the Community Mental Health Act was reeently passed by the State Legislature, and

Whereas, it is important for the medical profession to take the lead in mental health; therefore be it

RESOLVED: That all county medical societies establish a mental health committee to work with their local mental health boards to develop an active mental health program as passed by the State Legislature this year.

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman, recommended approval of this resolution.

The House adopted the recommendation of the Reference Committee.

Resolutions 12, 19, 20, 21, 22, 23, 32, 33, 45, 47, 55, 60, 61, 67, 69, and 70 were considered together by the Reference Committee on Medical Service and Prepayment Insurance.

No. 12—Requesting Michigan Medical Service to Withdraw Implementation of Relative Value Study

Introduced by Anthony C. Gholz, M.D., St. Clair

Whereas, Resolution No. 17, of the 1962 MSMS House of Delegates, referred the Relative Value Study to the Direetors of Michigan Medical Service for implementation as soon as practieal; and

Whereas, action was taken without study to determine the financial effect on various branches of medical practice; and

Whereas, the Board of Directors of Michigan Medical Service has eompleted such a study including computer data; and

Whereas, such study shows marked inequity in the paying of benefit as compared to the existing methods of distribution of financial proceeds; therefore be it

RESOLVED: That the House of Delegates request the Directors of Michigan Medical Service to withdraw implementation of the Michigan Relative Value Study until such inequity can be resolved.

No. 19—Need for Further Study Prior to Implementation of the Michigan Relative Value Scale

Introduced by R. M. Stow, M.D., Ingham

Whereas, the 1962 House of Delegates of the Michigan State Medical Society requested Michigan Medical Service to implement the Michigan Relative Value Fee Schedule at such time as considered practical; and

Whereas, Michigan Medical Service has indicated its intention to implement the Michigan Relative Value Fee Schedule; and

Whereas, recognition of the true effeet of manipulation of the x and y units was not realized by the members of the House of Delegates at the time it acted to instruct Michigan Medical Service; and

Whereas, the reapportionment of funds for payment tends to penalize one segment of medical practice rather than to affect all segments of medical practice on a pro-rata basis; and

Whereas, the structure of the Blue Cross-Blue Shield with its community rating policy will tend to require further adjustments in the Michigan Relative Value Fee Schedule; and

Whereas, such adjustments may not only further penalize other segments of medicine in the future but may act to influence insurance programs elsewhere in the United States; and

Whereas, the majority of radiologists in Michigan feel that the basis for implementation of the Michigan Relative Value Fee Schedule is unfair to radiology and will cause undue economic hardship; and

Whereas, organized radiology in Michigan has requested adjustments in fee schedules in order to make charges for service more realistic but has repeatedy been denied these requests by Michigan Medieal Service; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society further delay its instruction to Michigan Medical Service to implement the Michigan Relative Value Fee Schedule; and be it further

RESOLVED: That organized radiology in Michigan, through its official spokesman, the Detroit Roentgen Ray and Radium Society, be allowed to negotiate with Michigan Medical Service, a revised, equitable and practical fee schedule for x-ray diagnosis, radiation therapy and isotope procedures prior to any implementation of the Michigan Relative Value Fee Schedule by Michigan Medical Service.

No. 20—Further Study of Michigan Relative Value Scale

Introduced by J. P. Klein, M.D., Newaygo

Whereas, the 1962 House of Delegates adopted the report of the Relative Value Scale Committee and requested the Board of Blue Shield to implement use of this scale; and

Whereas, management of Blue Shield has completed a study of the effects of use of this scale in relation to the current fiscal position of Blue Shield and has submitted its findings to the Board of Directors, Blue Shield; and

Whereas, these findings propose a decrease of 20.4% in payment for diagnostic x-ray examinations with no other phase of medical practice remotely approaching such a financial base in their benefits; and

Whereas, implementation of this system for payments would produce an obvious inequity, forcing most or all of the radiologists in this State to ehoose between non-participation in the Blue Shield program or acceptance of a severe loss of income with little or no chance for modernization and replacement of equipment; and

Whereas, the rapid progress made in the field of radiology and all other branches of medical practice necessitates eon-

tinuous study of new procedures and establishment of values for them; therefore be it

RESOLVED: That the House of Delegates rescind the previous adoption of the Relative Value Scale; and be it further

RESOLVED: That the Board of Directors of Blue Shield be instructed *not* to implement use of this Relative Value Scale; and be it further

RESOLVED: That further study of the Relative Value Scale especially in the field of radiology be made by the Relative Value Study Committee and recommendations be submitted to the 1964 House of Delegates.

No. 21—Request MMS to Withhold Implementation of the Relative Value Study

Introduced by Herbert W. Devine, M.D., Wayne

Whereas, Resolution No. 17, of the 1962 MSMS House of Delegates, referred the Relative Value Study to the Directors of Michigan Medical Service for implementation as soon as practicable; and

Whereas, this action was taken without studies to determine the financial effect on various branches of medical practice; and

Whereas, the Board of Directors of Michigan Medical Service has completed such a study including computer data; and

Whereas, such studies show marked inequities in payment of financial proceeds as compared to existing methods of distribution of financial proceeds; therefore be it

RESOLVED: That the House of Delegates request the Directors of Michigan Medical Service to withhold implementation of the Relative Value Study until such inequities can be resolved.

No. 22—Reconsideration of the 1962 House of Delegates Adoption of the Michigan Relative Value Study

Introduced by Herbert W. Devine, M.D., Wayne

Whereas, the 1962 House of Delegates referred the Michigan Relative Value Study to be implemented by the Board of Directors of Michigan Medical Service as soon as practicable but without actual substantial figures to show what implementation would do to the proceeds of medical care; and

Whereas, the Board of Directors of Michigan Medical Service has completed such a study, the results of which show marked inequities in dividing the proceeds of medical care among the practitioners of Medicine; and

Whereas, the inequities are greater than those that exist in the present revised California Relative Value Scale now in use, therefore be it

RESOLVED: That this House of Delegates reconsider its action of 1962 in the light of actual figures arrived at by a thorough study by Michigan Medical Service including computer data.

No. 23—Inequity in Proposed Implementation of the Michigan Relative Value Study by Michigan Medical Service

Introduced by Herbert W. Devine, M.D., Wayne

Whereas, the 1962 House of Delegates has adopted the Michigan Relative Value Study; and

Whereas, the 1962 House of Delegates referred the Michigan Relative Value Study to be implemented by the Board of Directors of Michigan Medical Service as soon as practicable; and

Whereas, the Board of Directors of Michigan Medical Service has completed such a study including computer data preliminary to implementation; and

Whereas, the results of such study utilizing the x and y unit with the dividing point for use of the y unit being at seven units, has shown a marked inequity in dividing the proceeds of medical care among the practitioners of medicine; therefore be it

RESOLVED: That this House of Delegates request the Directors of Michigan Medical Service not to implement the Michigan Relative Value Study until such time as the error in the x and y unit or its division point of seven, be corrected to obtain equity in dividing the proceeds of medical care among the practitioners of medicine.

No. 32—Change in the Unit Values of Non-referral Diagnostic Radiologic Procedures

Introduced by W. Kaye Locklin, M.D., Kalamazoo

Whereas, Michigan Medical Service payments have increased faster than the allowed premium increases; and

Whereas, payments for radiologic diagnosis on a non-referral basis have increased and have become a significant expense to Michigan Medical Service; and

Whereas, radiologic diagnosis performed on a non-referral basis customarily is performed with less expensive and less complex equipment than is used for referred radiologic diagnostic consultation; therefore be it

RESOLVED: That the Relative Value Scale Committee be directed to consider the advisability of a reduced unit value for radiologic diagnosis done on a non-referral basis.

No. 33—Implementation of Michigan Relative Value Scale by Michigan Medical Service

Introduced by Robert F. Powers, M.D., Saginaw

Whereas, the Michigan Relative Value Scale was computed using a unit of $5.00 as a basis for study; and

Whereas, utilization patterns and limited monetary income which would lower the unit value to below $5.00 by Michigan Medical Service was not anticipated or considered; and

Whereas, it is now apparent that those branches of medicine that have a multitude of low value services, and relatively high fixed overhead costs would be adversely affected by a unit value below $5.00; therefore be it

RESOLVED: That the Michigan Medical Service be authorized not to implement the Michigan Relative Value Scale with less than a $5.00 unit at this time; and be it further

RESOLVED: That the Michigan Relative Value Scale be referred back to the Michigan Relative Value Study Committee for further consideration specifically on the problems concerning unit value fluctuations and utilization patterns.

No. 45—Relative Value Scale in Regard to X-Ray Service

Introduced by W. C. Beets, M.D., Kent

Whereas, the House of Delegates of the Michigan State Medical Society has accepted the Michigan Relative Value Scale and has requested the Board of Michigan Blue Shield to implement use of the scale; and

Whereas, study by the Board of Blue Shield has shown that the proposed use of the Michigan Relative Value Scale would result in a decrease of 20.4% in payments for diagnostic radiologic examination; and

Whereas, the fixed costs of radiologic practice are high and have increased rapidy during the past few years due to development of more powerful and more complex basic equipment, image intensification, and cine; and

Whereas, the proposed 20.4% decrease in payments would reduce net income of radiologists of this state an average of more than 50%; and

Whereas, no other section of practice would make any even remotely comparable sacrifice of income; and

Whereas, adoption of the Michigan Relative Value Scale in the form proposed by Michigan Blue Shield would force all or most radiologists and hospital radiologic departments to become non-participating; and

Whereas, the radiologic section of the Michigan Relative Value Scale proposes value appreciably lower than those proposed by the American College of Radiology from study of fees in several states; and

Whereas, use of the proposed Michigan Relative Value Scale would make needed modernization and expansion of equipment in hospital departments of radiology and of radiologic offices economically impossible; and

Whereas, provision of modern diagnostic service to patients throughout this state would therefore be seriously hampered; and

Whereas, future changes in the various fields of practice will require continuing study of changes in the Michigan Relative Value Scale; therefore be it

RESOLVED: First that the Board of Blue Shield be instructed to postpone use of the Michigan Relative Value Scale until it has been reviewed by the Relative Value Scale Committee; and be it further

RESOLVED: Second that the Relative Value Scale Committee shall be directed to review the radiologic portion of the Relative Value Scale and report its recommendations to the House of Delegates; and be it further

RESOLVED: Third that the Relative Value Scale Committee shall make a continuing survey of the Michigan Relative Value Scale by consideration of pertinent subjects brought to it by members of the Michigan State Medical Society and shall report annually to the House of Delegates its recommendations on each subject considered.

No. 47—Conversion Factors in Sections of Michigan Relative Value Study

Introduced by Ross V. Taylor, M.D., Jackson

Whereas, the published Michigan Relative Value Study of 1961 integrated the sections of surgery, medicine, pathology, and x-ray; and

Whereas, the integration is valid only when the *average fees* for all sections are determined and a *common denominator* is used; and

Whereas, uniform variations in coversion factors will result in unequal variations in physicians' net incomes in the different sections because of the variance in gross income and cost factors; and

Whereas, variation in the conversion factors which might be unfair to any section should be minimized or avoided; therefore be it

RESOLVED: That the Michigan Relative Value Study Committee be directed to separate the four sections in a way that will permit different basic units for each section if indicated; and be it further

RESOLVED: That Michigan Medical Service be requested to consult the Michigan State Medical Society for assistance in determining conversion factors which vary from the average or basic factor used to determine relative value units from average fees.

ADDENDUM TO RESOLUTION No. 47

Examples of variations in net income if across the board changes in conversion factors are used and assuming that all of the physicians' income might be derived from plans or agencies using the Relative Value Scale and conversion factor changes:

		Conversion Factor			
		Average (5.00 unit)	10% Decrease (4.50 unit)	20% Decrease (4.00 unit)	30% Decrease (3.50 unit)
A	Gross	$60,000	$54,000	$48,000	$42,000
	Cost	20,000	20,000	20,000	20,000
	Net	$40,000	$34,000	$28,000	$22,000
	% Change in Net		15%	30%	45%
B	Gross	$50,000	$45,000	$40,000	$35,000
	Cost	20,000	20,000	20,000	20,000
	Net	$30,000	$25,000	$20,000	$15,000
	% Change in Net		16⅔%	33⅓%	50%
C	Gross	$40,000	$36,000	$32,000	$28.000
	Cost	10,000	10,000	10,000	10,000
	Net	$30,000	$26,000	$22,000	$18,000
	% Change in Net		13⅓%	26⅔%	40%

No. 55—Inequity in Proposed Implementation of the Michigan Relative Value Study by Michigan Medical Service

Introduced by H. Clay Tellman, M.D., Muskegon

Whereas, the 1962 House of Delegates adopted the Michigan Relative Value Study proposed to them after, as stated by them, a thorough survey; and

Whereas, the 1962 House of Delegates referred this Michigan Relative Value Study to the Board of Directors of Michigan Medical Service to be implemented as soon as practicable; and

Whereas, the Board of Directors of Michigan Medical Service through their Board personnel has completed such a study, including computer data, preliminary to this implementation authorized by the House of Delegates in 1962; and

Whereas, the results of such study utilizing the x and y units, with the dividing point for the use of the y unit being at seven units, has shown a marked inequity in dividing the proceeds of medical care among the practitioners of medicine; and

Whereas, this inequity in dividing the proceeds results from a failure to evaluate the Relative Value Study as it applies to radiology; and

Whereas, the Relative Value Study as adopted after a thorough national study of Relative Value Studies was compiled, as regards radiology and published in 1963; therefore be it

RESOLVED: That this House of Delegates rescinds the adopted 1962 Relative Value Schedulue as it applies to the field of radiology and isotopes and orders the directors of Michigan Medical Service not to implement the Michigan Relative Value Schedule until such time as the inequities are corrected with thorough re-evaluation of the Relative Value Study in the field of radiology giving careful study to the schedule adopted by the American College of Radiology with proper evaluation of the dollar value of the unit.

No. 60—Re-evaluation of Michigan Relative Value Concept

Introduced by William J. Yott, M.D., Wayne

Whereas, it is important that the physicians of the State of Michigan unify their thoughts and interests for the preservation of the practice of Medicine; and

Whereas, at present there are many differences of opinion as to the principles and modes of action the physician should use to accomplish this unity; and

Whereas, multiple theories and plans for accomplishing this are constantly being submitted; and

Whereas, the Relative Value Scale as adopted by the House of Delegates of MSMS has already created dissention among our members before being implemented by Michigan Medical Service resulting in division of our ranks; and

Whereas, there is already a trend to reduce incomes of physicians when all other incomes are increasing according to the cost of living; now therefore be it

RESOLVED: That consideration be given to the House of Delegates of MSMS to re-introduce the Relative Value Scale with the intention of eliminating it or to reaffirm our confidence in it; and be it further

RESOLVED: That there be re-evaluation of the concept of service benefit contracts for the low income groups.

No. 61—Unit Value for Use by Michigan Medical Service

Introduced by William L. Brosius, M.D., Wayne

Whereas, it has come to the attention of the Michigan Pathological Society there is a contemplated reduction of 15% in unit value to be instituted at the time of the institution of the new Michigan Relative Value Schedule; and

Whereas, we charge one fee for a service on all contracts regardless of income; and

Whereas, our fees for services have remained essentially unchanged for approximately ten years in spite of increasing costs; and

Whereas, our fees for service were not raised when the present M-75 contract was instituted; therefore be in

RESOLVED: That the Michigan Pathological Society go on record as recommending that the House of Delegates of the Michigan State Medical Society recommend to the Michigan Medical Service that the unit value for pathological services be kept at a level no lower than the present established unit value of $5.00.

No. 67—Hearings on Michigan Relative Value Schedule

Introduced by G. S. Fisher, M.D, Wayne

Whereas, the Michigan Relative Value Schedule has been approved by the MSMS for implementation by MMS and also as a basis of negotiating schedules with governmental agencies; and

Whereas, the Michigan Relative Value Scale points out and corrects certain inequities in patient benefits which have existed for many years; and

Whereas, there is a mechanism through the RVS Committee for corrections or adjustments of suggested possible inequities; therefore be it

RESOLVED: That the Michigan State Medical Society reaffirms approval and implementation forthwith of the Michigan Relative Value Schedule in place of the California Relative Value Schedule; and be it further

RESOLVED: That the Michigan State Medical Society direct the Relative Value Study Committee to expedite hearings from all segments of the profession who have requests for changes or improvements in the Michigan Relative Value Schedule.

No. 69—Hearings on Michigan Relative Value Schedule

Introduced by N. L. Avery, Jr., M.D., Kent

Whereas, the Michigan Relative Value Schedule has been approved by the MSMS House of Delegates for implementation by MMS and also as a basis for negotiating schedules with governmental and other agencies: and

Whereas, the Michigan Relative Value Schedule corrects certain inequities in patient benefits which have existed for many years; and

Whereas, there is mechanism through the Relative Value Study Committee for corrections and adjustments of suggested possible inequities; therefore be it

RESOLVED: That the MSMS reaffirm approval of the Michigan Relative Value Schedule in place of the California Relative Value Schedule, and direct MMS to implement the schedule forthwith; and be it further

RESOLVED: That the MSMS direct the Relative Value Study Committee to hold continuing hearings from all segments of the profession who may request changes or improvements in the Michigan Relative Value Schedule.

No. 70—Hearings on Michigan Relative Value Schedule

Introduced by Harold L. Oster, M.D., Jackson

Whereas, the Michigan Relative Value Schedule has been approved by the Michigan State Medical Society for implementation by MMS and also as a basis for negotiating schedules with governmental agencies; and

Whereas, the Michigan Relative Value Scale points out and corrects certain inequities in patient benefits which have existed for many years; and

Whereas, there is a mechanism through the Relative Value Study Committee for corrections or adjustments of suggested possible inequities; therefore be it

RESOLVED: That the Michigan State Medical Society reaffirm approval of the Michigan Relative Value Schedule in place of the California Relative Value Schedule; and be it further

RESOLVED, That the Michigan State Medical Society direct the Relative Value Study Committee to expedite hearings from all segments of the profession who have requests for changes or improvements in the Michigan Relative Value Schedule.

The Reference Committee on Medical Service and Prepayment Insurance, J. B. Blodgett, Chairman, presented the following report:

"Because of the similarity of content of Resolutions Nos. 12, 18, 20, 21, 22. 23, 32, 33, 45, 47, 55, 60, 61, 67, 69, and 70, we considered them together.

Your Reference Committee recognizes that, in order to function, any prepayment plan requires a fee schedule related to service. The Committee affirms that individuals who set fees should be those who provide the services—in this case doctors of medicine as represented by the Michigan State Medical Society and not by Michigan Medical Service.

"The present Relative Value Study Committee is knowledgeable in this field and has a desire and ability to properly and fairly reconsider this problem which is so important both to the physicians of Michigan and the subscribers of Michigan Medical Service. Accordingly, it would seem necessary that the Relative Value Study Committee have an opportunity to reconsider these matters.

"We therefore introduce a substitute resolution for these several resolutions:

Substitute Resolution

'**Whereas,** the 1962 House of Delegates of the Michigan State Medical Society requested Michigan Medical Service to implement the Michigan Relative Value Scale at such time as it considered practical; and

'**Whereas,** the Board of Directors of Michigan Medical Service has completed and forwarded its study including computer data to the 1963 House of Delegates for the information of its members; and

'**Whereas,** it has been alleged that there are inequities present which require further study of economic considerations and discussion with all segments of the medical profession of Michigan; and

'**Whereas,** the actual setting of fees is a prerogative of the Michigan State Medical Society and not Michigan Medical Service, a third party; therefore be it

'**RESOLVED:** That the Relative Value Scale be not implemented at this time by the Michigan Medical Service; and be it further

'**RESOLVED:** That the problem of these alleged inequities be recommitted to the presently constituted Relative Value Study Committee; and be it further

'**RESOLVED:** That any revised scale developed by the Relative Value Study Committee be submitted to Michigan Medical Service for monetary interpretation only, without implementation, and then return to the House of Delegates at a special or the next regular meeting, whichever is practicable.' "

The Reference Committee recommended approval of the Substitute Resolution.

The House amended the Substitute Resolution by striking the last "Whereas."

The House adopted the Report of the Reference Committee, as amended.

Resolutions No. 13 and No. 14 were introduced in conjunction and referred to the Reference Committee on Hygiene and Public Health.

No. 13—Definition of Public Health

Introduced by Otto K. Engelke, M.D., Delegate-at-Large

Whereas, the newly adopted Constitution of the State of Michigan provides that: "All executive and administrative offices, agencies, and instrumentalities of the executive branch of state government and their respective functions, powers and duties, except for the office of governor and lieutenant governor and the governing bodies of institutions of higher education provided for in this constitution, shall be allocated by law among and within not more than 20 principal departments. They shall be grouped as far as practicable according to major purposes"; and

Whereas, in the present structure of Michigan state government there are a multiplicity of separate boards, agencies, and commissions which administer programs related to various aspects of health; and

Whereas, these activities of state departments in the health field may properly be considered to be public health functions and it would be in the best interests of the people of Michigan if they were consolidated by law within the Department of Health; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society recommends to the Michigan Legislature that, in its consolidation of health functions in the State Health Department, it be guided by the definition as set forth by the House of Delegates of the American Medical Association in 1962 in its statement supplementing an outline of the basic six public health services: "Public health is the art and science of maintaining. protecting, and improving the health of the people through organized community efforts. It includes those arrangements whereby the community provides medical services for special groups of persons and is concerned with prevention or control of disease, with persons requiring hospitalization to protect the community and with the medically indigent."

The Reference Committee on Hygiene and Public Health,

E. M. Vardon, M.D., Chairman, recommended approval of the following report: "Strike out the first 'Whereas' and the 'RESOLVED' portion. In the second 'Whereas,' put a semicolon after 'public health functions,'; delete the words 'and that it would be in the best interests of the people of Michigan,' substituting for the phrase: 'therefore, be it RESOLVED.'"

The House adopted the recommendation of the Reference Committee.

Resolutions No. 14 and No. 13 were introduced in conjunction and referred to the Reference Committee on Hygiene and Public Health.

No. 14—Limitation of Powers of Health Department

Introduced by Otto K. Engelke, M.D., Delegate-at-Large

Whereas, the newly adopted Constitution of the State of Michigan provides that: "All executive and administrative offices, agencies and instrumentalities of the executive branch of state government and their respective functions, powers, and duties, except for the office of governor and lieutenant governor and the governing bodies of institutions of higher education provided for in this constitution, shall be allocated by law among and within not more than 20 principal departments. They shall be grouped as far as practicable according to major purposes"; and

Whereas, the House of Delegates of the American Medical Association, in 1962, defined the basic six services of public health to be: (a) vital statistics, (b) public health education, (c) environmental sanitation, (d) public health laboratories, if private facilities are unavailable, (e) prevention and control of communicable diseases, and (f) hygiene of maternity, infancy and childhood, if private facilities are unavailable, but opened the door to a much broader definition of public health in a statement following these basic six services; and

Whereas, in the consolidation of powers, duties and functions of existing state instrumentalities of government, vigilance should be exercised by the Michigan State Legislature to avoid incorporation of programs under public health which are not basic public health services and which are properly the purview of organized community efforts, of private medicine, and the voluntary agencies; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society recommends to the Michigan Legislature that the activities of the State Health Department be limited by law to the six basic services enumerated above.

The Reference Committee on Hygiene and Public Health, E. M. Vardon, M.D., Chairman, recommended disapproval of Resolution 14, "inasmuch as it was contradictory and took the opposite view of No. 13, which has been approved."

The House did not approve the recommendation of the Reference Committee. It amended Resolution No. 14 by adding the following "RESOLVED": ". . . and be it further

"RESOLVED: That this resolution be approved as a general principle and that by law certain restrictions should be placed on the Department of Health in its relationship to the remainder of State's medical function. However, because of the very complicated and many faceted aspects of this problem, a special committee of The Council should be immediately set up to influence and cooperate with the State Legislature."

The House adopted Resolution No. 14, as amended, and referred it to The Council for further study.

Resolutions No. 15 and No. 16 were introduced in conjunction and referred to the Reference Committee on Hygiene and Public Health.

No. 15—Retention of Medical Functions by Social Welfare Department

Introduced by Otto K. Engelke, M.D., Delegate-at-Large

Whereas, the Michigan Medical Assistance to the Aged Law is implemented by the Michigan Department of Social Welfare at the direction of the legislature; and

Whereas, the several county, district, and city departments of social welfare and the bureaus of social aid throughout Michigan provide a necessary experienced mechanism for the efficient determination of eligibility for, and the provision of hospital, physician, and other services under this law; and

Whereas, similarly, the State Department of Social Welfare and the welfare offices of local units of government have long administered the medical aspects of the old age assistance program, rehabilitation and treatment of the blind, and other medical social services; and

Whereas, the Department of Health is not established in all of the counties of Michigan and, therefore, would not be in a position to properly administer these important programs; and

Whereas, the reallocation of these medical services to any other department of government would result in a massive dislocation of systems and records which would be costly, confusing and detrimental to the provision of necessary medical care to the people of Michigan; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society recommends to the Michigan Legislature that it provide for the continuity of all medical programs currently administered by the Department of Social Welfare within that department of any governmental reorganization undertaken under the new Michigan Constitution.

The Reference Committee on Hygiene and Public Health, E. M. Vardon, M.D., Chairman, recommended referral to a committee of The Council.

The House adopted this recommendation of the Reference Committee.

Resolutions No. 16 and No. 15 were introduced in conjunction and referred to the Reference Committee on Hygiene and Public Health.

No. 16—Transfer of Welfare Medical Functions to Health Departments

Introduced by Otto K. Engelke, M.D., Delegate-at-Large

Whereas, the Michigan State Department of Social Welfare was created by the State Legislature in 1939 to protect the welfare of the people of this State; and

Whereas, although in its current sense "welfare" has reference to economic status, the medical aspects of welfare are separate from the major function of this agency; and

Whereas, those functions, powers and duties presently allocated by law to the Department of Social Welfare which are medical in nature should be reallocated to a principal department whose major purpose is related to the field of health; and

Whereas, the State Health Commissioner is in general charge and supervision of the enforcement of the health laws of this state; and

Whereas, it would be in the best health interests of the people of Michigan to consolidate the health functions of state government in a single agency which is specifically devoted to health matters, such as the Department of Health, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society recommends to the Michigan Legislature that the administration of medical services incorporated in public welfare programs, particularly the Medical Assistance to the Aged Program, be transferred from the Department of Social Welfare to the Department of Health.

The Reference Committee on Hygiene and Public Health, E. M. Vardon, M.D., Chairman, recommended approval of the principle, expressed in this Resolution, but because of difficulty in implementing the Resolution in twelve counties at the present time, the Reference Committee referred this Resolution to a committee of The Council along with Resolution No. 15.

The House adopted the recommendations of the Reference Committee.

Resolutions No. 17 and 18 were introduced in conjunction and referred to the Reference Committee on Hygiene and Public Health.

No. 17—Separate Mental Health Department

Introduced by Otto K. Engelke, M.D., Delegate-at-Large

Whereas, the Michigan Department of Mental Health has been a separate agency of state government for eighteen years since its inception in 1945; and

Whereas, the State Mental Health Department, in terms of budget, a total number of employees and the extent of its plant and facilities is one of the largest agencies in Michigan State government; and

Whereas, the medical aspects of the Department of Mental Health are oriented solely to mental hygiene, there being sixteen major state institutions in the Department's complex under the direction of physicians especially trained in the treatment of the mentally afflicted; and

Whereas, recently enacted Michigan laws and trends in federal mental health legislation tend toward the establishment of a new approach to the treatment of the mentally ill, in community-based clinics, and the implementation of such programs can best be directed by a department which places its primary emphasis upon mental health; and

Whereas, Michigan legislation was enacted in 1963 clearly stating the intent of the Legislature that mental health be administered separately from other health programs; and

Whereas, the combination of the present Mental Health Department with any other major department in state government would create a super-agency to vast, complex and diverse for the efficient management which would be in the best health interests of the people of Michigan; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society recommends to the Michigan Legislature that in its reorganization of state agencies it provide for a single, separate principal department to deal with mental health.

The Reference Committee on Hygiene and Public Health, E. M. Vardon, M.D., Chairman, recommended disapproval of this Resolution.

The House adopted the recommendation of the Reference Committee.

Resolutions No. 18 and No. 17 were introduced in conjunction and referred to the Reference Committee on Hygiene and Public Health.

No. 18—Mental Health Combined with Department of Health

Introduced by Otto K. Engelke, M.D., Delegate-at-Large

Whereas, the Michigan State Health Commissioner, since this office was established by the Legislature in 1919, has been charged with responsibility for supervision and enforcement of the health laws of the State of Michigan; and

Whereas, in 1945 the Legislature abolished the state hospital commission and created in its stead a department of mental health for the operation of the mental disease institutions of the State; and

Whereas, the current emphasis on supplanting major mental disease institutions with community mental health clinics and other types of community-based programs will eventually result in the elimination or reduction of the large state mental institutions which the Department of Mental Health was originally created to manage; and

Whereas, the State Health Department, in conducting its public health activities, is officially established in most of the counties of Michigan with long experience in implementing its program through and in cooperation with local units of government; and

Whereas, mental health and physical health are inseparable and the field of medicine and health concerns itself with the total individual; and

Whereas, mental health laws are clearly health laws of the State of Michigan and as such should be supervised and enforced by the State Health Commissioner; and

Whereas, all other public health programs bear a significant relationship to the mental health of the people so that a coordination of all health programs will be in the best interests of the people of Michigan; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society recommends to the Michigan Legislature that in its reorganization of state agencies it provide that one of the twenty principal departments encompass both the functions of the present Health Department and the present Mental Health Department under a single executive.

The Reference Committee on Hygiene and Public Health, E. M. Vardon, M.D., Chairman, deleted the last three words of the last paragraph, placing a period after the words "Mental Health Department" and adding the sentence: "The chief administrator should be a doctor of medicine," and recommended approval, as amended.

The House did not adopt the recommendation of the Reference Committee, but adopted a motion to refer Resolution No. 18 to The Council.

Nos. 19, 20, 21, 22 and 23 were considered together with Nos. 12, 32, 33, 45, 47, 55, 60, 61, 67, 69 and 70, by the Reference Committee on Medical Service and Prepayment Insurance. The resolutions and report of House action appear on pages 30, 31, 32, and 33.

No. 24—Legislation to Permit Health Insurance Pooling Plans

Introduced by Otto K. Engelke, M.D., Delegate-at-Large

Whereas, the medical profession of Michigan, speaking through this House of Delegates of the Michigan State Medical Society, has for many years demonstrated its vital concern for the medical and health welfare of the people of this state, and has taken concrete and progressive steps to continually improve the same through the adoption of specific resolutions aimed particularly at care for the aging through the advocacy in 1961 of the concept of voluntary prepayment funding plans for paid-up at age 65 health insurance or medical care programs, and the recommendation in 1962 of health insurance pooling plans; and

Whereas, voluntary prepayment medical service plans and the health insurance industry are now providing substantial and increasing coverage for the people of the State of Michigan, thus assuring a far higher quality of medical care than can any governmental mechanism; and

Whereas, plans to provide insurance coverage against financial loss from accident and sickness for persons 65 years of age and over, under which two or more insurance companies join together in organizations to offer, sell and administer hospital, surgical and medical expense insurance plans under a group policy, have been adopted in over a dozen states since the successful operation of such plans in Connecticut, Massachusetts and New York, and

Whereas, the feasibility of such plans is currently undergoing study by both the Michigan State Medical Society and by the Michigan insurance companies engaged in the writing of accident and health business, and an appropriate committee of the Michigan insurance industry has undertaken to prepare a draft of legislation which would authorize the writing of such coverage in Michigan; now therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society notes with gratification the efforts and progress of the Michigan insurance industry toward the development of a suitable plan of medical, hospital and surgical coverage for the senior citizens of this state through a joint arrangement of insurers under a voluntary health program; and be it further

RESOLVED: That the Michigan State Medical Society pledges its continuing support in these efforts and urges the adoption by the Michigan State Legislature of the required enabling legislation to permit the creation of pooling programs which provide coverages of greater adequacy at less cost to Michigan citizens over age 65 and their spouses.

The Reference Committee on Legislation and Public Relations, L. A. Drolett, M.D., Chairman, recommended approval of the resolution as introduced.

The House adopted the recommendation of the Reference Committee.

No. 25—In Appreciation

Introduced by Robert K. Whiteley, M.D., Wayne

Whereas, Mr. William J. Burns was Executive Secretary of the Wayne County Medical Society from 1929-1935; and

Whereas, since that date he has worked diligently for the physicians in Michigan as Executive Director of the Michigan State Medical Society; and

Whereas, as Executive Secretary of the Wayne County Medical Society and as Executive Director of the Michigan State Medical Society he has served faithfully, competently and enthusiastically; therefore be it

RESOLVED: That the 1963 House of Delegates express to Mr. Burns on behalf of the physicians in Michigan their sincere appreciation for his service and their best wishes for a rewarding retirement: and be it further

RESOLVED: That a copy of this resolution be engraved and presented to Mr. Burns.

The Reference Committee on Ways and Means, N. L. Avery, M.D., Chairman, amended the second "RESOLVED" to read: "an expression of this 'RESOLVED' be presented to Mr. Burns by the House of Delegates in the form of a plaque", and recommended approval of the Resolution, as amended.

The House adopted the recommendation of the Reference Committee.

No. 26—Motor Vehicle Inspection Laws

Introduced by John G. Slevin, M.D., Wayne

Whereas, the National Safety Council has pointed out that many highway accidents are caused by faulty maintenance of safety features in automobiles; and

Whereas, auto manufacturers have made efforts through engineering research and otherwise to provide automobiles that are mechanically as safe as they possibly can be made at this time: and

Whereas, the intricate mechanism of automobiles does require periodic maintenance to maintain these built-in safety features; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society urges the Michigan Legislature to pass a compulsory motor vehicle inspection and repair law so that unsafe autos may be excluded from the highways; and be it further

RESOLVED: That a copy of this resolution be sent to each member of the Legislature of Michigan, Detroit Traffic Safety Council, and the National Safety Council.

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman, in the last "RESOLVED" changed the word "Detroit" to "municipal," added an "s" to Council in the second line and recommended approval of the Resolution, as amended.

The House adopted the recommendation of the Reference Committee.

Resolutions Nos. 27, 29, and 48 were considered together by the Reference Committee on Miscellaneous Business.

No. 27—Anti-Cigarette Smoking

Introduced by T. J. Dillon, M.D., Van Buren

Whereas, there is ever-increasing evidence that cigarette smoking bears a direct relationship to serious respiratory pathology, and

Whereas, prevention of this pathology is possible but cure improbable, therefore be it

RESOLVED: That

1. MSMS urge the Michigan State Legislature to enact legislation making it mandatory to have stamped on all packages of cigarettes sold in the State of Michigan a statment containing a warning that excessive use is dangerous to health, this statement to be in letters as large as the largest letters on the labeling.

2. The Committee on Scientific Exhibits for the Michigan State Medical Society meeting refuse to allow any form of tobacco advertising in the exhibits as a protest to the unethical methods utilized by the tobacco companies in habituating youngsters.

3. MSMS charge either The Council's Committee on Alcoholism and Drug Addition or our Public Health Committee with a program of education stressing the prophylactic benefits of non-smoking.

No. 29—Health Hazards of Smoking

Introduced by Ross V. Taylor, M.D., Jackson

Whereas, the excessive smoking of tobacco is recognized as being injurious to the general health and especially to the cardio-vascular and respiratory systems; and

Whereas, the habituation to smoking tobacco makes its use difficult to curb or control; and

Whereas, the habituation to tobacco smoking is frequently acquired or initiated by teen-agers and minors; therefore be it

RESOLVED: That the Michigan State Medical Society exert its leadership in preventive medicine and use all available means to educate the public and especially teen-agers concerning the health hazards associated with smoking of tobacco; and be it further

RESOLVED: That the Michigan State Medical Society urge enforcement of existing laws and ordinances concerning the sale and use of tobacco and especially those laws concerning minors; and be it further

RESOLVED: That the Michigan State Medical Society encourage legislation to curb and restrict tobacco advertising which might influence adolescents and teen-agers to use tobacco; and be it further

RESOLVED: That the Michigan State Medical Society initiate educational programs and also publicly support other health agency programs which properly educate the public concerning the potential health hazards of tobacco; and be it further

RESOLVED: That these resolutions of the Michigan State Medical Society be publicized as a matter of public education; and be it further

RESOLVED: That similar resolutions be forwarded to the American Medical Association.

No. 48—Cigarette Smoking

Introduced by Jack Rom, M.D., Wayne

Whereas, the Michigan State Medical Society is concerned with all matters relating to public health; and

Whereas, the Michigan State Medical Society is cognizant of its responsibilities to the citizens of the State of Michigan; and

Whereas, the preponderance of evidence indicates that cigarette smoking is implicated in the genesis of lung cancer, contributes to the development of other diseases, notably cardiovascular, and is detrimental to health in other fields, therefore be it

RESOLVED: That the Michigan State Medical Society go on record as urging those already habituated to give up cigarette smoking; and be it further

RESOLVED: That the Michigan State Medical Society initiate and maintain a program to publicize the harmful effects of cigarette smoking, and to promote an educational program, particularly in schools and homes, to keep young people from starting the habit of smoking cigarettes.

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman, considered Resolutions 27, 29, 48 together and recommended disapproval of Nos. 27 and 29. It recommended approval of Resolution No. 48 with the deletion of the third "Whereas" and the first "RESOLVED."

The House adopted the recommendations of the Reference Committee.

No. 28—Composition of Public Health and Legal Affairs Committees

Introduced by Frank Perkin, M.D., Wayne

Whereas, in the near future important decisions will be made and laws passed governing the practice of medicine in Michigan; and

Whereas, considerable weight in respect to such actions will be given to the opinions and actions of the Public Health

and the Legal Affairs Committee of the Michigan State Medical Society; therefore be it

RESOLVED: That the Chairman of the Public Health Committee and the Legal Affairs Committee of the Michigan State Medical Society and a substantial majority of both Committees be private practitioners of medicine.

The Reference Committee on Resolutions, R. E. Wunsch, M.D., Chairman, recommended approval of the following:

Substitute Resolution

"**Whereas,** in the immediate future important decisions will be made and laws passed governing the practice of Medicine in the State of Michigan; and

"**Whereas,** considerable weight in respect to such actions will be given to the opinions and actions of the Public Health and the Legal Affairs Committees of the Michigan State Medical Society; and

"**Whereas,** the advice, opinions, and labors of those members of the Michigan State Medical Society who are members of the Public Health Services, and others not engaged in the private practice of Medicine, have been and will be valuable to the deliberations of these Committees; and

"**Whereas,** public health physicians should have proportionate representation on these Committees; therefore, be it

"**RESOLVED:** That 75 to 80 per cent of these Committees' memberships be composed of physicians in private practice, and that the Chairman be from the majority group."

The House amended the Substitute Resolution by placing a period after the word "practice" in the "RESOLVED" and deleting the seven words which follow:

The House adopted the Substitute Resolution as amended by the House.

No. 29 was considered together with Nos. 27 and 48 by the Reference Committee on Miscellaneous Business. The resolutions and report of House action appear on page 36.

No. 30—Governmental Restrictions on Michigan Medical Service

Introduced by Ross V. Taylor, M.D., Jackson

Whereas, the Michigan Medical Service has agreed that all rate increases must be submitted to the Michigan State Insurance Commissioner for approval, and

Whereas, the Insurance Commissioner has demonstrated that this authority can disapprove and prevent rate increases even though the solvency of Michigan Medical Service may be at stake, and

Whereas, recent rate increases approved by the Insurance Commissioner have not and will not permit the development of reasonable reserves for Michigan Medical Service, and

Whereas, increasing utilization has constantly and primarily absorbed all rate increases approved to date and therefore has prevented Michigan Medical Service from improving some subscriber benefits, and

Whereas, forced restrictions of proper actions upon Michigan Medical Service from a governmental agency were never envisioned by the Michigan State Medical Society when Michigan Medical Service was formulated and "the doctors' plan" initiated, therefore be it

RESOLVED: That the Michigan State Medical Society refer the following questions to each component county medical society for their consideration and discussion and crystallization of membership opinions:

1. Can Michigan Medical Service continue to be properly responsive to the will of the Michigan State Medical Society as formulated by its House of Delegates?

2. Should the members of the Michigan State Medical Society accept proration of fees in a situation where rate increases consistent and necessary for increasing utilization and improved medical care are not approved by the Insurance Commissioner and the solvency of the Michigan Medical Service is threatened or destroyed?

3. Will the problem of increasing subscriber discontent with rising premium rates lead to an increasingly poor public image and public relations for the Michigan State Medical Society even though the greater costs are directly related to utilization frequency and improved medical care?

4. Will service contracts for a majority of the population and subject to the whims of a governmental agency approval lead to a freeze on fee schedules and eventually make the medical profession completely subservient to some governmental agency or program?

5. Should Michigan Medical Service limit service contracts and community rating to low income subscribers and otherwise compete in the open market with free enterprise commercial carriers in indemnity programs for other subscribers?

6. Have health insurance and prepayment programs for medical care become so inclusive and complicated that most busy physicians are no longer able to become adequately informed so as to make the intelligent decisions necessary for the preservation and perpetuation of the basic principles of American Medicine?

7. Should the Michigan State Medical Society consider that circumstances might force the Michigan State Medical Society to withdraw sponsorship of Michigan Medical Service?

8. Should the county medical societies individually study the advisability of each county society developing a "Foundation" for medical care such as those presently functioning in many other states, especially California?

The Reference Committee on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, reported "This Resolution refers certain questions to each component society for its consideration, discussion, and crystallization of membership opinions. The Reference Committee is in favor of a knowledgeable membership and the help it can give its parent society, and, therefore, moves the adoption of this Resolution.

The House adopted the recommendation of the Reference Committee.

No. 31—Third Medical School

Introduced by Mahlon S. Sharp, M.D., Ingham

Whereas, the profession has always supported the high standards of medical education and the expansion of facilities to meet the needs of the population, and

Whereas, the committee for planning higher education in Michigan recommended completion of the plans at the University of Michigan Medical School and enlargement of the facilities of Wayne State University College of Medicine to their maximum and a two-year medical school at Michigan State University; and

Whereas, with the completion of this terminal phase of these programs the establishment of a third medical school in Michigan has been recommended, and

Whereas, it is generally well recognized that a medical school is best located on a university campus where there are extensive facilities in related biological science and that in the future these related fields may indeed lead the way and are of increasing importance; therefore be it

RESOLVED: That the MSMS recommend to the Legislature that the Third Medical School be established by the expansion of the existing two-year school at Michigan State University.

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman, reported there had been insufficient time for adequate study of the Resolution and it, therefore, recommended that it be referred to The Council for further study.

The House adopted the recommendation of the Reference Committee.

Nos. 32 and 33 were considered together with Nos. 12, 19, 20, 21, 22, 23, 45, 47, 55, 60, 61, 67, 69 and 70, by the Reference Committee on Medical Service and Prepayment Insurance. The resolutions and report of House action appear on pages 30, 31, 32, and 33.

No. 34—Non-Emergency Medical Care *Not* a Contract Benefit

Introduced by V. V. Bass, M.D., Saginaw

Whereas, hospital emergency rooms have gradually developed into "out-patient clinics" so that at present only 20% to 40% of patients seen are "emergency" patients, and

Whereas, this has produced a situation of harassment for hospital personnel and administrators and for physicians; and

Whereas, Michigan Medical Service (Blue Shield) does not recognize non-surgical out-patient care as a contract benefit since fiscal responsibility for such benefits would be financially impractical, and

Whereas, MMS does consider such out-patient hospital care a contract benefit; and

Whereas, this places an ever-increasing financial burden on MHS, and

Whereas, MHS and MMS should equate contract benefits to subscribers so that a recognized benefit by the one would also be recognized by the other, therefore be it

RESOLVED, That the corporate body of MMS strongly recommend to the corporate body of MHS that non-emergency out-patient care *not* be considered a contract benefit.

The Reference Committee on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, reported it did not feel it had adequate facts to take responsible action and, therefore, recommended the Resolution be referred to the Standing Committee to Study Emergency Care in Hospitals.

The House adopted the recommendation of the Reference Committee.

No. 35 was considered together with Nos. 2, 41, 57 and 58 by the Reference Committee on Legislation and Public Relations. The resolutions and report of House action appear on page 27.

No. 36—Community Health Week Observance

Introduced by V. V. Bass, M.D., Saginaw

Whereas, one of the greatest assets of our communities is the health and safety of their citizens; and

Whereas, the citizens of Michigan are blessed with many excellent health services through community efforts and planning; and

Whereas, the American Medical Association is initiating a nationwide program for Community Health Week, October 20-26, and is seeking cooperation and support of all organizations with a major interest in health to encourage our communities to plan for the health needs of the future; and

Whereas, the Michigan Health Council and the Michigan Association of the Professions have indicated their willingness to cooperate in the observance of this Week; therefore be it

RESOLVED: That the Michigan State Medical Society give its full support to the observance of the 1st Annual Community Health Week in cooperation with the Michigan Health Council and the Michigan Association of the Professions; and be it further

RESOLVED: That the Governor of Michigan and the mayors of Michigan cities be urged to join in its observance; and be it further

RESOLVED: That all component societies of the MSMS be urged to take action as quickly as possible to participate in and encourage community activity in this observance.

The Reference Committee on Legislation and Public Relations, L. A. Drolett, M.D., Chairman, recommended approval of the Resolution.

The House adopted the recommendation of the Reference Committee.

No. 37—Token of Appreciation to Executive Director Burns

Introduced by E. H. Rodda, Bay-Arenac-Iosco

Whereas, Mr. William J. Burns has announced his retirement as Executive Director of the Michigan State Medical Society; and

Whereas, for nearly 29 years, Mr. Burns has devoted his considerable talents and boundless energy to the operation of the MSMS organizational structure, and

Whereas, MSMS and Michigan medicine have grown during these 29 years, and due credit should be extended to the MSMS "Chief of Staff," therefore be it

RESOLVED: That this House of Delegates consider presenting a tangible token of appreciation to the retiring MSMS Executive Director.

The Reference Committee on Ways and Means, N. L. Avery, M.D., Chairman, recommended approval with referral to the Finance Committee of The Council for implementation.

The House adopted the recommendation of the Reference Committee.

No. 38—Small Plant Medical Services

Introduced by H. L. Gordon, M.D., Midland

Whereas, the health of the working man, physical and mental, is directly related to his productivity; and

Whereas, a majority of the small plant occupational health programs are administered by physicians in private practice on a part-time basis; and

Whereas, the Occupational Health Council of the American Medical Association has seen fit to formulate a statement of principle on the scope, objectives and functions of occupational health programs and publish a guide to "Small Plant Occupational Health Programs" to implement said statement, and

Whereas, the Occupational Health Committee of the Michigan State Medical Society in their sub-committee report on Small Plant Medical Services has defined the problem as it related to the State of Michigan and has made recommendations for improvement of existing programs and the development of new ones; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society accept the report of the Occupational Health Committee and instruct said Committee to proceed with the educational program outlined therein; and be it further

RESOLVED: That the report of the Occupational Health Committee on Small Plant Services be printed in an early issue of the MSMS Journal.

The Reference Committee on Standing Committees, R. V. Taylor, M.D., Chairman, recommended "disapproval of this Resolution, not because of its intent but because the educational program outlined in the first 'RESOLVED,' has not been made available for review and approval by any committee or functioning body of the MSMS.

The House adopted the recommendation of the Reference Committee.

No. 39—Standard Disability Form

Introduced by H. L. Gordon, M.D., Midland

Whereas, an unnecessary degree of confusion is occasioned by the current utilization of a multiplicity of disability forms by the major industries and insurance carriers; and

Whereas, a distinct service could be rendered to Michigan industry and insurance carriers by creation of a mutually acceptable standard disability form; therefore be it

RESOLVED: That the Michigan State Medical Society, in consultation with interested specialty groups, propose to the Michigan State Association of Life Underwriters the creation of an ad hoc liaison committee, whose purpose would be the development of a standard disability form, which would subsequently be recommended for exclusive utilization by employers and all insurance carriers in the State.

The Reference Committee on Hygiene and Public Health, E. M. Vardon, M.D., Chairman, recommended approval of the Resolution.

The House disapproved the recommendation of the Reference Committee. The Resolution was not approved because of belief that confusion would result from adding to "standard forms" already approved and in use.

No. 40—Qualifications for Physicians

Introduced by A. W. Blain, M.D., Wayne

Whereas, the qualification for membership in the Michigan State Medical Society is an M.D. degree and a license to practice medicine in Michigan and good ethical and moral character; and

Whereas, the membership of the Michigan State Medical Society includes doctors of medicine of many races and creeds, and

Whereas, the professional qualifications of physicians are based on education, training, and experience; therefore be it

RESOLVED: That the Michigan State Medical Society reemphasize its policy of embracing all ethical doctors of medicine without regard for their race or creed, and be it further

RESOLVED: That all those concerned with providing health care be urged to appraise physicians only on the basis of their ability, professional qualifications and good moral and ethical character.

The Reference Committee on Resolutions, R. E. Wunsch, M.D., Chairman, recommended approval of the Resolution with the amendments to the first "RESOLVED" so that it reads as follows: "RESOLVED: That the Michigan State Medical Society reaffirm its well-established policy, of many years' duration, of embracing all ethical doctors of medicine without regard for their race or creed."

The House adopted the recommendation of the Reference Committee.

No. 41 was considered together with Nos. 2, 35, 57 and 58 by the Reference Committee on Legislation and Public Relations. The resolutions and report of House action appear on page 27.

No. 42 was considered together with No. 8 by the Reference Committee on Miscellaneous Business. The resolutions and report of House action appear on page 27.

No. 43—Full Utilization of Hospital Facilities and Equipment

Introduced by E. J. Tallant, M.D., Wayne

Whereas, the cost of operation of hospital facilities and equipment is dependent upon the amount of utilization; and

Whereas, utilization of hospital facilities and equipment is not maximum; and

Whereas, physicians are concerned with the constantly rising cost of hospitalization; therefore be it

RESOLVED: That the Michigan State Medical Society recommends that hospitals utilize their facilities and equipment to their maximum capacity and insofar as possible function seven days a week; and be it further

RESOLVED: That a copy of this resolution be forwarded to the Michigan Hospital Association with the request that its members be urged to implement this recommendation.

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman, reported it believed this was an individual hospital staff problem and, therefore, recommended disapproval of the Resolution.

The House adopted the recommendation of the Reference Committee.

No. 44—Blue Cross Inequities

Introduced by F. P. Rhoades, M.D., Wayne

Whereas, Blue Cross enjoys unlimited autonomy in its decision as to which hospitals are granted recognition as participating institutions; and

Whereas, under present day practice such recognition is necessary if a general hospital is to remain solvent; and

Whereas, such discriminatory action denies holders of Blue Cross-Blue Shield contracts free choice of hospital and physician and forces them to travel appreciable distances to hospitals which have been granted participation; and

Whereas, even when additional hospital beds are needed in a given area and a hospital in that area with adequate facilities, fully licensed and accredited by the State Board of Health and having a competent medical staff has been refused recognition as a participating hospital by Blue Cross; therefore be it

RESOLVED: That the MSMS House of Delegates go on record as condemning the arbitrary abuse of its powers by Blue Cross.

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman recommended disapproval of the Resolution.

The House adopted the recommendation of the Reference Committee.

No. 45 was considered together with Nos. 12, 19, 20, 21, 22, 23, 32, 33, 47, 55, 60, 61, 67, 69 and 70 by the Reference Committee on Medical Service and Prepayment Insurance. The resolutions and report of House action appear on pages 30, 31, 32, and 33.

No. 46—Medical Identification Plans

Introduced by G. S. Fisher, M.D., Wayne

Whereas, medical science now allows many people formerly limited by chronic illness to be as active and exposed to danger as healthy people; and

Whereas, the knowledge of type of illness and medication is of utmost importance in emergency situations; and

Whereas, a uniform means for identification of pertinent medical information is lacking; and

Whereas, a social security card is issued to most adults; therefore be it

RESOLVED: That the Department of Health, Education and Welfare be requested to provide space on the social security card for such pertinent information; and be it further

RESOLVED: That number-related duplicate cards be issued to minor dependents of the card-holder for similar identification.

The Reference Committee on Emergency Medical Service, M. L. Lichter, M.D., Chairman, recommended adoption of the following substitute resolution. "The Committee was entirely in accord with the intent of this Resolution. However, noting that this problem has been dealt with by the American Medical Association, your Reference Committee wished to present the following substitute resolution:

Substitute Resolution

"**Whereas,** the knowledge of the type of illness which a patient may have and the medication which he is taking is of utmost importance in an emergency situation; and

"**Whereas,** the American Medical Association has developed an excellent identification card and medallion which is readily available; therefore be it

"**RESOLVED:** That the Michigan State Medical Society develop a continuing program of acquiring these identification items and make them available to physicians at no cost, upon request, for distribution to their patients; and be it further

"**RESOLVED:** That at the Centennial Health Fair the public be informed of the importance and value of such medical identification and the ready availability of such material which can be distributed upon request at the Fair."

The House adopted the recommendation of the Reference Committee.

No. 47 was considered together with Nos. 12, 19, 20, 21, 22, 23, 32, 33, 45, 55, 60, 61, 67, 69 and 70, by the Reference Committee on Medical Service and Prepayment Insurance. The resolutions and report of House action appear on pages 30, 31, 32, and 33.

No. 48 was considered together with Nos. 27 and 29 by the Reference Committee on Miscellaneous Business. The resolutions and report of House action appear on page 36.

No. 49 was withdrawn by the introducer.

No. 50—Election of Blue Shield Board of Directors

Introduced by K. T. McGunegle, M.D., Sanilac

Whereas, the material accompanying the names of candidates for the Board of Directors of Blue Shield tells little of the candidates except that they are members of the Society and neither in their nonage or dotage; and

Whereas, there is not enough information to enable the Delegate to cast his vote to implement his own and his constituents' views; therefore be it

RESOLVED: That this House of Delegates request Blue Shield to revise its election rules so that each candidate for the Board of Directors shall make, and cause to be published, a statement of his philosophy regarding Blue Shield and his reasons for seeking the position.

The Reference Committee on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, reported: "We recognize that as much data as possible should be available on candidates before an election, but we recognize also that a statement of a candidate's philosophy would not be an adequate index of his usefulness as a member of the Board. For this reason we recommend no action on this resolution."

The House adopted the recommendation of the Reference Committee.

No. 51—Staff Privileges for Psychiatrists

Introduced by K. T. McGunegle, M.D., Sanilac

Whereas, the trends toward more specialization and compartmentalization of the practice of medicine is apparently increasing; and

Whereas, this practice often results in inefficient and inadequate care of many patients who require mental and spiritual aid in addition to physical aid; and

Whereas, it appears that closed staffs contribute much to this problem; therefore be it

RESOLVED: That this Society recommend to the hospital staffs of this State that provision be made for liberal use of psychiatrists, in a consulting capacity, in the hospitals to the end that an accredited psychiatrist may have entry to any hospital to assist in the care of his patients.

The Reference Committee on Resolutions, R. E. Wunsch, M.D., Chairman, recommended the following amendments: delete third "Whereas," amend "RESOLVED" to read: "RESOLVED: That this Society recommend to the hospital staffs and psychiatric associations of this State that provision be made for liberal use of psychiatrists in a consulting capacity."

The House adopted the recommendation of the Reference Committee.

No. 52—Amendment to Federal Income Tax Laws

Introduced by Milton R. Weed, M.D., Wayne

Whereas, necessary expenditures for medical care and drugs should be encouraged in the interest of optimum health of the total nation; and

Whereas, there are inequities at present in the income tax provisions for medical expenditures because some workers have the full cost of prepayment medical care provided by their employers which is tax exempt and many others do not; and

Whereas, the American Medical Association is on record as favoring the "Amendment of the income tax laws to permit taxpayers to deduct all medical payments for over 65 dependents, as well as more liberal medical and drug deductions rules for elderly taxpayers; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society instruct the Council to support federal legislation to amend the Internal Revenue Code to provide for full deduction of all medical care expenses (including drugs), not compensated for by a tax exempt (fringe benefit) program, incurred by a taxpayer in his own behalf or in behalf of his legal dependents.

The Reference Committee on Legislation and Public Relations, L. A. Drolett, M.D., Chairman, recommended approval of the following amendments:

Amend the first "Whereas", to read: "Whereas, necessary expenditures for medical care should be encouraged for the total good health of the nation;"

Amend the "RESOLVED" to read: "RESOLVED: That the House of Delegates of the MSMS instruct The Council to support federal legislation to amend the Internal Revenue Code to provide for deduction of premiums of prepaid medical care insurance incurred by any taxpayer in his own behalf or his legal dependents."

The House adopted the recommendations of the Reference Committees.

No. 53—Kent County Health Fair

Introduced by Robert E. Rice, M.D., Ionia-Montcalm

Whereas, the Kent Medical Foundation as the instrument of the Kent County Medical Society successfully conducted an outstanding Health Fair in Grand Rapids during Michigan Week, May 19-25, 1963; and

Whereas, nearly 100,000 Michigan youths and adults attended this week-long event thereby obtaining a better understanding of sound medical and health practices and the biological sciences; and

Whereas, hundreds of students were afforded an opportunity to discuss career opportunities with members of the health team and view the work and exhibits of more than 150 health organizations; therefore be it

RESOLVED: That the Michigan State Medical Society express its admiration and thanks to the Kent Medical Foundation and its members, under the leadership of Joseph R. Lentini, M.D., for sponsoring and carrying out such a valuable project to its successful conclusion; and be it further

RESOLVED: That copies of this resolution be transmitted to Dr. Lentini and to the Kent County Medical Society.

The Reference Committee on Resolutions, R. E. Wunsch, M.D., Chairman, recommended approval of this Resolution.

The House adopted the recommendation of the Reference Committee.

No. 54—Commendation for Joseph C. Foust, M.D.

Introduced by Robert E. Rice, M.D., Ionia-Montcalm

Whereas, Joseph C. Foust, M.D., left a well-established, lucrative practice in Ionia, Michigan, some four years ago and, accompanied by his wife and eight children, went to Tukuyu, Tanganyika, East Africa, to provide medical care for thousands of the impoverished needy people so prevalent in that part of the world; and

Whereas, not being sponsored by any group or church, his being personally responsible for all his expenses, underscores the depth of his sincerity; and

Whereas, Doctor Foust, because of deep personal convictions, plans to make this his life work and continue his selfless service to those in distressing need; therefore be it

RESOLVED: That the Ionia-Montcalm Medical Society individually and collectively commend this devoted humanitarian who came from our midst. We extend our admiration and pledge our wholehearted support of his exemplary undertaking; and be it further

RESOLVED: That this commendation be read before the Annual Session of the MSMS so they may share with us the pride and concern we feel for Doctor Foust and his work and the credit he reflects on our profession.

The Reference Committee on Special Committees, J. G. Slevin, M.D., Chairman, recommended that both "RESOLVEDS" be stricken and that the following "Whereas" and "RESOLVED" be substituted:

"**Whereas,** the Ionia-Montcalm Medical Society has commended Dr. Foust for his humanitarian work and exemplary undertaking; therefore be it

"**RESOLVED:** That the House of Delegates of the Michigan State Medical Society concurs in this commendation of Joseph C. Foust, M.D."

The House adopted the recommendation of the Reference Committee.

No. 55 was considered together with Nos. 12, 19, 20, 21, 22, 23, 32, 33, 45, 47, 60, 61, 67, 69 and 70, by the Reference Committee on Medical Service and Prepayment Insurance. The resolutions and report of House action appear on pages 30, 31, 32 and 33.

No. 56—Michigan Health Fair—1965

Introduced by Luther R. Leader, M.D., Wayne

Whereas, the year 1965 will mark the year of the "Centennial Celebration" of the founding of the Michigan State Medical Society; and

Whereas, the Grand Rapids Health Fair in 1963 proved to be such a success, both in public relations and education; therefore be it

RESOLVED: That a similar Health Fair be presented in Detroit concurrent with the 100th (Centennial) Anniversary of the Michigan State Medical Society; and be it further

RESOLVED: That the Arrangements Committee for the contemplated Health Fair (previously appointed) by given instructions to proceed with plans and arrangements, the latter to be submitted to The Council before signing any binding contractural agreements.

The Reference Committee on Ways and Means, N. L. Avery, M.D., Chairman, recommended approval with the following amendment to the second "RESOLVED", to read: "That this matter be referred to The Council for implementation."

The House adopted the recommendation of the Reference Committee.

Nos. 57 and 58 were considered together with Nos. 2, 35 and 41 by the Reference Committee on Legislation and Public Relations. The resolutions and report of House action appear on page 27.

No. 59—Relationship of Physicians not in Private Practice to Organized Medicine

Introduced by Otto K. Engelke, M.D., Delegate-at-Large

Whereas, the American Medical Association has made a comprehensive study of Relationships of Physicians Not-in-Private Practice to Organized Medicine and has recommended that constituent and component societies make every effort to bring physicians not in private practice into full, active voting membership by appropriate amendment of the Bylaws of such constituent and component societies and to re-evaluate their programming so as to make medical society meetings and activities of interest to physicians not in private practice as well as to those in private practice; and

Whereas, the Michigan State Medical Society is in full accord with the basic aims and purposes of such recommendations; now therefore be it

RESOLVED: That

(1) The Council of the Michigan State Medical Society be instructed to recognize, in planning society programs and activities, the policy of encouraging the interest and participation of physicians not in private practice and to encourage and stimulate component societies to adopt such policy.

(2) The Standing Committee on Constitution and Bylaws be instructed to study and consider such changes in the Bylaws of the Society as will be required to permit physicians not in private practice to become full, active voting members, and to report its recommendations in relation thereto at the next annual meeting of the House of Delegates.

The Reference Committee on Constitution and Bylaws, R. R. Cooper, M.D., Chairman, took no action on this resolution because it was considered together with 1962 Resolution No. 3. The Reference Committee recommended action only on the latter resolution, as amended. (See Annual Report of the Standing Committee on Constitution and Bylaws.)

The House adopted this action of the Reference Committee.

Nos. 60 and 61 were considered together with Nos. 12, 19, 20, 21, 22, 23, 32, 33, 45, 47, 55, 67, 69 and 70, by the Reference Committee on Medical Service and Prepayment Insurance. The resolutions and report of House action appear on pages 30, 31, 32, and 33.

No. 62 was considered together with No. 46 by the Reference Committee on Constitution and Bylaws. The resolutions and report of House action appear on pages 28 and 39.

No. 63—Code of Understanding Between Physicians and Pharmacists

Introduced by Byron P. Brown, M.D., Eaton

Whereas, there is need for understanding between the medical and pharmaceutical professions relating to problems of health care; and

Whereas, the Joint Commission on Medicine and Pharmacy has recommended formation of liaison committees at the state and local level; and

Whereas, the Council of the Michigan State Medical Society has recommended that its component societies form liaison committees between medicine and pharmacy; and

Whereas, such liaison committees in order to properly function must have guidelines by which they can review mutual areas of concern; and

Whereas, the Michigan State Pharmaceutical Association by action of their House of Delegates has approved a code of understanding between physicians and pharmacists; and

Whereas, the Liaison Committee of the MSMS and MSPA has reviewed and recommended the adoption of this code between our two health professions; therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society recognize the need for establishing the guideline through which the liaison committees of the component societies can effectively function and respectfully urge The Council to give careful consideration toward the adoption of this code.

The Reference Committee on Resolutions, R. E. Wunsch, M.D., Chairman, recommended approval, amending the "RESOLVED" to read:

"RESOLVED: That the House of Delegates of the MSMS recognize the need for establishing the guidelines through which the liaison committee of the component societies can effectively function, and respectfully urge The Council to give careful consideration toward the development of a code to be subsequently submitted to the House of Delegates of the MSMS."

The House adopted the recommendation of the Reference Committee.

No. 64 was considered together with No. 6 by the Reference Committee on Legislation and Public Relations. The Resolutions and report of House action appear on pages 28 and 29.

No. 65—Medical Members of Hospital Boards

Introduced by Alexander Blain, III, M.D., Wayne

Whereas, the House of Delegates of the Michigan State Medical Society did recommend that Hospital Boards of Trustees have at least one Doctor of Medicine as a member of each Board; and

Whereas, there has been only little implementation by Michigan Hospital Boards of Trustees; and

Whereas, the reason for their action in this regard by the 1962 House of Delegates was to transmit to such Hospital Boards of Trustees the medical profession's viewpoint better than can be done by Joint Conference Committees; and

Whereas, the Michigan Hospital Association has only objected to this resolution; therefore be it

RESOLVED: That the House of Delegates reaffirm the position of the Michigan State Medical Society that each Hospital

Board avail itself of the services of one or more physician members; and be it further

RESOLVED: That their action be transmitted directly to every member of Hospital Boards of Trustees in this state.

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman, recommended approval of the Resolution.

The House adopted the recommendation of the Reference Committee.

No. 66—University Hospital for Wayne State University

Introduced by A. W. Blain, III, M.D., Wayne

Whereas, Detroit is a wonderful location for a first rate medical school by virtue of the potential teaching value of its large population; and

Whereas, for almost a century, medical schools in Detroit have labored in a political environment resulting from lack of control of their own teaching hospitals; and

Whereas, there is now the beginning of a third medical school at Michigan State University; therefore be it

RESOLVED: That the Michigan State Medical Society recommend to the State Legislature and the Detroit Common Council that funds for metropolitan Detroit hospital construction place top priority on the construction of a Wayne State University Hospital, to be under the control of faculty clinicians.

The Reference Committee on Legislation and Public Relations, L. A. Drolett, M.D., Chairman, submitted the following report: "Mr. Chairman, it was brought out in the discussion of this Reference Committee that this Resolution is almost identical to the one presented to the last House of Delegates and referred to the Wayne County Medical Society for action, and no action has been forthcoming so far.

The Reference Committee recommended that no action be taken on this Resolution at this time, and that the Resolution be referred back to the Wayne County Medical Society with the recommendation that specific action be taken by the Wayne County Medical Society and a report brought back to the next session of the House of Delegates."

The House adopted the report of the Reference Committee.

No. 67 was considered together with Nos. 12, 19, 20, 21, 22, 23, 32, 33, 45, 47, 55, 60, 61, 69 and 70, by the Reference Committee on Medical Service and Prepayment Insurance. The resolutions and report of House action appear on pages 30, 31, 32, and 33.

No. 68—Blue Shield Non-Participation

Introduced by E. M. Vardon, M.D., Wayne

Whereas, the enabling act under which Blue Cross and Blue Shield operate definitely states that there shall be no renumeration of any kind to the policyholder; and

Whereas, it has been repeatedly emphasized that there can be no discrimination between members of the Michigan State Medical Society and that they must be treated equally in all respects; and

Whereas, precedence and a 25-year custom of treating all doctors alike, would definitely carry legal weight in court; therefore be it

RESOLVED: That the Michigan State Medical Society advise Michigan Medical Service that there can be no discrimination in treatment of its members, and that participating and non-participating physicians be treated alike.

The Reference Committee on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, reported "Whereas the Reference Committee disapproves of discrimination between participating and non-participating physicians, but in view of the consent judgment which makes MMS unable to implement this concept, we recommend no action on this Resolution."

The House did not adopt the recommendation of the Reference Committee.

The House amended the Resolution, deleting the first "Whereas," and substituting the word "should" for the word "can" in the second line of the "RESOLVED."

The House adopted the Resolution, as amended.

Nos. 69 and 70 were considered together with Nos. 12, 19, 20, 21, 22, 23, 32, 33, 45, 47, 55, 60, 61 and 67, by the Reference Committee on Medical Service and Prepayment Insurance. The resolutions and report of House action appear on pages 30, 31, 32, and 33.

No. 71—Endorsement of Fiscal Reform

Introduced by Charles J. Tupper, M.D., Washtenaw

Whereas, MSMS recognizes its responsibility as a group of citizens; and

Whereas, MSMS has traditionally stood for justice and equity; therefore be it

RESOLVED: That MSMS endorse Governor Romney's plan for fiscal reform.

The Reference Committee on Legislation and Public Relations, L. A. Drolett, M.D., Chairman, recommended approval of the Resolution.

The House adopted the recommendation of the Reference Committee.

No. 72—A Resolution of Recognition and Appreciation of Otto K Engelke, M.D.

Introduced by Paul Ivkovich, M.D., Mecosta-Osceola-Lake

Whereas, by reason of the adoption of a new State Constitution and the consideration by the Legislature of an unusual number of important bills affecting the medical profession, this past year has been an exceptionally active and time-consuming one for the Legal Affairs Committee; and

Whereas, Otto K. Engelke, M.D., the Chairman of that Committee has, with wisdom, acute perception and tireless efforts, contributed services of inestimable value to the Society; now therefore be it

RESOLVED: That the sincere appreciation and wholehearted commendation of the Society is hereby extended to Otto K. Engelke, M.D.

The Reference Committee on Resolutions, R. E. Wunsch, M.D., Chairman, recommended approval of the Resolution.

The House adopted the recommendation of the Reference Committee.

No. 73—Michigan Minute Men and American Medical Political Action Committee

Introduced by A. B. Gwinn, M.D., Barry

Whereas, the Michigan Minute Men were organized in 1952; and

Whereas, the American Medical Political Actions Committee has been organized since that date and patterned to a great extent after our own Michigan Minute Men; and

Whereas, our Michigan Minute Men as well as American Medical Political Action Committee is a non-partisan organization; and

Whereas, both our State and National organizations are fighting to keep our American way of life and private enterprise alive; therefore be it

RESOLVED: That this House of Delegates give its approval, and urge the members of Michigan State Medical Society to support Michigan Minute Men and American Medical Political Action Committee by both word and deed.

The Reference Committee on Legislation and Public Relations, L. A. Drolett, M.D., Chairman, recommended disapproval of the Resolution, and recommended "that instead of supporting two efforts, all efforts should be directed to the support of AMPAC, and that all members of the MSMS be urged to join and contribute to AMPAC."

The House adopted the recommendation of the Reference Committee.

No. 74—Merger of Osteopathic and Medical Professions in the State of Michigan

Introduced by C. Jackson France, M.D., Wayne

Whereas, the State of Michigan now has more practicing Osteopathic physicians than any other state; and

Whereas, the increasing number of osteopathic hospitals had created a duplication of hospital facilities in many communities; and

Whereas, an increasing number of community hospitals are facing the problem of mixed medical physicians-osteopathic physician staffs: and

Whereas, the establishment of an osteopathic medical school has been proposed for the State of Michigan: therefore be it

RESOLVED: That the MSMS House of Delegates establish a Study Committee to make recommendations to the Legislature for the implementation of the California Plan for the merger of the Osteopathic and Medical Professions in the State of Michigan.

The Reference Committee on Miscellaneous Business, P. T. Lahti, M.D., Chairman, reported "Last night, the House of Delegates approved Recommendation No. 2 of the Annual Report of the House of Delegates Ad Hoc Committee to Study Relationship Between Doctors of Medicine and Doctors of Osteopathy" which recommended that the Committee be continued. "Your Reference Committee feels that the subject matter of Resolution No. 74 will be thoroughly studied by that Committee. Therefore, the Reference Committee recommends disapproval of Resolution No. 74.

The House adopted the report of the Reference Committee.

No. 75—Ad Hoc Committee to Study the Procedure of the House of Delegates

Introduced by John G. Slevin, M.D., Wayne

Whereas, the present procedures of the House of Delegates require study to determine if revisions are necessary so that the House of Delegates may operate more efficiently; therefore be it

RESOLVED: That an Ad Hoc Committee of the House of Delegates be appointed by the Spcaker to study this problem and report at the next session of the House of Delegates.

The Reference Committee on Resolutions, R. E. Wunsch, M.D., Chairman, recommended approval of the Resolution.

The House adopted the recommendation of the Reference Committee.

Special Memberships

The Reference Committee on Special Memberships, Paul Ivkovich, M.D., Chairman, recommended approval of the following special memberships recommended by the component medical societies:

Life Memberships

Branch County: Perry C. Beck, M.D.

Calhoun County: Clifford W. Brainard, M.D.

Genesee County: William P. Boles, M.D.; Nicholas Del Zingro, M.D.; Rita B. Tower, M.D.

Gogebic County: M. J. Lieberthal, M.D.

Grand Traverse County: R. R. Huston, M.D.; Fred G. Swartz, M.D.

Jackson County: Cecil Corley, M.D.; Elmore F. Lewis, M.D.; William E. McGarvey, M.D.

Ingham County: Charles A. Behney, M.D.; Russell L. Finch, M.D.

Kent County: Joe DePree, M.D.; John H. Wenger, M.D.

Livingston County: Ray H. Duffy, M.D.

Manistee County: Homer A. Ramsdell, M.D.

Marquette-Alger County: William A. Corcoran, M.D.; William A. Mudge, M.D.; Joseph S. McCarthy, M.D.

Oakland County: Ira M. Altshuler, M.D.; Clifford T. Ekelund, M.D.; Howard B. Barker, M.D.; Sol M. Lewis, M.D.; John D. Monroe, M.D.; John C. Montgomery, M.D.; Isaac C. Prevette, M.D.; Ruth E. Wagner, M.D.; Otto O. Beck, M.D.

Saginaw County: Archer A. Claytor, M.D.

St. Clair County: Howard O. Brush, M.D.; Dorsey W. Patterson, M.D.; George E. Sands, M.D.

Washtenaw County: Carl E. Badgley, M.D.; James J. Woods, M.D.; Orus R. Yoder, M.D.

Wayne County: Domenico M. Annessa, M.D.; Walter F. Bach, M.D.; Elden C. Baumgarten, M.D.; Isadore 1. Bittker, M.D.; Franklin T. Bower, M.D.; Joseph Bleier, M.D.; DeWitt T. Burton, M.D.; Clarence M. Clark, M.D.; Wyman C. C. Cole, M.D.; Darrell B. Galerneau, M.D.; E. Walter Hall, M.D.; Winfred B. Harm, M.D.; James W. Hawkins, M.D.; Harold Henderson, M.D.; Arthur Isaacson, M.D.; Hans A. Jarre, M.D.; Hubert R. John, M.D.; Traian Leucutia, M.D.; Edward D. King, M.D.; Earl C. Long, M.D.; Edwin H. Lorantzen, M.D.; Malcolm D. MacQueen, M.D.; Carleton J. Marinus, M.D.; James A. Morley, M.D.; John W. Nagle, M.D.; Karl G. Pinckard, M.D.; Frank H. Purcell, M.D.; Isaac S. Schembeck, M.D.; W. La Rue Sherman, M.D.; Harold W. Stubbs, M.D.; Elmer C. Texter, M.D.; Roy D. Tupper, M.D.; David Weingarden, M.D.

Retired Memberships

Bay County: Clyde S. Tarter, M.D.

Houghton County: Earl C. Potter, M.D.

Kent County: Garnet G. Stonehouse, M.D.

Muskegon County: Enid Fillingham, M.D.; Everett W. Gaikema, M.D.

Oakland County: Willard G. Beattie, M.D.; Cleo R. Gatley, M.D.; Etta Link Leahy, M.D.

Ottawa County: William Heard, M.D.

Wayne County: Daniel Budson, M.D.; James E. Caraway, M.D.; James A. Flower, M.D.; John W. Hansen, M.D.; Daniel E. Hasley, M.D.; Clayton T. Stubbs, M.D.; Charles N. Weller, M.D.; Donald C. Young, M.D.

Associate Memberships

Washtenaw County: Jerry W. Anderson, M.D.; Paul J. Benson, M.D.; Raymond E. Culver, M.D.; Trygve O. Gabrielsen, M.D.; Joseph G. Gough, M.D.; James A. Greene, Jr., M.D.; Dewey R. Heetderks, M.D.; Herbert Kaufer, M.D.; Francis J. Kenney, Jr., M.D.; S. Martin Lindenauer, M.D.; John T. McGreer, M.D.; Barbara A. Mella, M.D.; Jerome I. Millman, M.D.; Miles J. Murphy, M.D.; Donald F. Nagler, M.D.; Robert M. Oneal, M.D.; Bruce A. Pattee, M.D.; Maurice S. Pelto, M.D.; Daniel L. Reed, M.D.; J. Bernard Sloan, M.D.; Robert E. Stevens, M.D.; Joseph J. Tiziani, M.D.; Laurence C. Wegienka, M.D.; John E. White, M.D.

Wayne County: Harry E. Bagley, M.D.; Alice E. Palmer, M.D.; Lawrence A. Pratt, M.D.; Gisela Schroeder, M.D.; Wadworth Warren, M.D.

The House adopted the recommendation of the Reference Committee.

GENERAL MEETING AND ELECTIONS

GENERAL MEETING OF MSMS

The House went into a recess for a General Meeting of the Michigan State Medical Society—President Owen presiding.

In an appropriate ceremony the insignia of the President of the Michigan State Medical Society was transferred from President Owen, to O. J. Johnson, M.D., who was installed as the President of the Michigan State Medical Society.

President Johnson then presented to Immediate Past President Owen a scroll, which read as follows:

"Presented by the Michigan State Medical Society to Clarence 1. Owen, M.D., President, 1962-63, in deep appreciation and grateful recognition of the distinguished service rendered to medicine."

CERTIFICATES OF COMMENDATION

Doctor Owen, as presiding officer, presented the following Certificates of Commendation as authorized by the House of Delegates:

Forest D. Dodrill, M.D., Bloomfield Hills—

"In recognition of his contributions and early research in heart-lung bypass procedures. A thoracic and cardiovascular

surgeon, author, teacher and leader in many medical organizations. He has merited an illustrious reputation."

Charles J. Jentgen, M.D., Detroit—
"For outstanding contributions to medicine in Michigan. In recognition of his contributions during more than fifty years of medical practice as a surgeon, a teacher and a medical administrator."

John M. Sheldon, M.D., Ann Arbor—
"In recognition of his outstanding contributions in medical education, especially in the field of postgraduate medical education. He is a nationally-known authority in allergy and an illustrious leader in the important work of professional medicine."

Homer H. Stryker, M.D., Kalamazoo—
"In recognition of his contributions as an orthopedic surgeon and an inventor of orthopedic equipment. Long active in youth and athletic affairs, he is a popular speaker on behalf of free enterprise."

FIFTY YEAR AWARDS

At the request of Doctor Owen, Secretary D. Bruce Wiley, M.D., presented the 50 Year Award to the following:

Leon M. Bogart, M.D., Flint
Clarence L. Candler, M.D., Detroit
Elisha W. Caster, M.D., Oak Park
Lowry C. M. Conley, M.D., Detroit
Frank B. Gerls, M.D., Pontiac
Raymond E. Hillmer, M.D., Painesdale
Isaac S. Lilly, M.D., Stanton
Roy A. Morter, M.D., Kalamazoo
Dorsey W. Patterson, M.D., Port Huron
Milton C. Smith, M.D., Mt. Clemens
F. G. Swartz, M.D., Traverse City
C. Stuart Wilson, M.D., Alpena

Doctor Wiley read the following names of 50 Year Awardees who were unable to be present:

Guy D. Briggs, M.D., Flint
Frederick A. Coller, M.D., Ann Arbor
O. P. Geib, M.D., Gaylord
Howard Havers, M.D., Detroit
William Huyser, M.D., Kalamazoo
Charles S. Kennedy, M.D., Detroit
Gordon S. McAlpine, M.D., Detroit
William R. McClure, M.D., Boynton Beach, Florida
Robert C. Moehlig, M.D., Detroit
Harold L. Morris, M.D., Detroit
Harold F. Ohrt, M.D., Detroit
William D. Ryan, M.D., St. Petersburg, Florida
Maurice L. Richardson, M.D., Lansing
Ernest C. Schultz, M.D., Detroit
F. Janney Smith, M.D., Grosse Pointe Farms
Grant Thorburn, M.D., Waynesboro, Pennsylvania
William Rae Young, M.D., Lawton

EMPLOYEE AWARDS

Secretary Wiley read the following list of employees of headquarters staff and the years of service they had given to the Michigan State Medical Society:

William J. Burns—28 years
Helen A. Schulte—20 years
Hugh W. Brenneman—17 years
Robert J. Roney—15 years
Vada L. Davis—11 years
Warren F. Tryloff—9 years
Margaret Cornwell—7 years
Lester P. Dodd—7 years
Mary K. Brewbaker—6 years
Delta M. Berry—6 years

Miss Helen Schulte, with 20 years of service, and Mr. Robert Roney with 15 years of service were called forward to receive their awards. The awards are given on anniversary dates at five-year intervals, as authorized by Resolution No. 24 of the 1960 House of Delegates.

PRESENTATION OF AWARD TO WM. J. BURNS

The following award, authorized by the House of Delegates, was presented to Mr. Burns by President Owen:

"In tribute to William J. Burns, retiring as Executive Director of the Michigan State Medical Society, December 31, 1963. On behalf of the 7,000 members of the Michigan State Medical Society, this House of Delegates pays tribute to Bill Burns for his leadership in helping the medical profession of Michigan and the nation make progress toward their high goals. During the past 28 years his selfless devotion to the doctors of medicine and the Michigan State Medical Society has left an indelible mark on the structure of this Society, and a warm spot in the hearts of all who know him."

TRIBUTE TO DECEASED MEMBERS OF THE HOUSE OF DELEGATES

Berrien County
D. W. Thorup, M.D., Delegate 1941 through 1959
Chippewa-Mackinac County
I. V. Yale, M.D., Alternate 1943
Genesee County
T. S. Conover, M.D., Alternate 1941-42
W. H. Winchester, M.D. (1955 Foremost Family Physician)
Ionia-Montcalm County
Earl B. Bunce, M.D., Alternate 1946
Saginaw County
F. E. Luger, M.D., Alternate 1957
Shiawassee County
R. C. Pochert, M.D., Alternate 1945
Wayne County
R. C. Andries, M.D., Delegate 1937-1938, Alternate 1942
Milton A. Darling, M.D., Past President, Delegate 1942 through 1958
William S. Gonne, M.D., Delegate 1942-43-44, Alternate 1945-46
William M. Tuttle, M.D., Delegate 1960-61-62

Also deceased this past year: Wilfrid Haughey, M.D., Editor Emeritus of The Journal, Michigan State Medical Society.

[The House stood in silent tribute to the deceased members.]

ELECTIONS

The following Councilors and Officers were elected:

President-elect—Oliver B. McGillicuddy, M.D., Lansing

Speaker—James J. Lightbody, M.D., Detroit

Vice-Speaker—Louis F. Hayes, M.D., Gaylord

Councilors—
First District: W. C. C. Cole, Sr., M.D., Detroit (to 1965); Edward J. Tallant, M.D., Detroit (to 1966); Robert K. Whiteley, M.D., Detroit (to 1964)
Second District: Ross V. Taylor, M.D., Jackson (to 1966)
Third District: Harvey C. Hansen, M.D., Battle Creek (to 1966)
Ninth District: Robert V. Daugharty, M.D., Cadillac (to 1966)
Tenth District: Harold Kessler, M.D., Alpena (to 1965)
Eleventh District: Brooker L. Masters, M.D., Fremont (to 1966)
Twelfth District: James R. Dehlin, M.D., Gladstone (to 1965)
Thirteenth District: D. Roemer Smith, M.D., Iron Mountain (to 1966)
Fifteenth District: Robert J. Mason, M.D., Birmingham (to 1965)

Delegates to the American Medical Association—
John R. Heidenreich, M.D., Daggett
W. A. Hyland, M.D., Grand Rapids
Orlen J. Johnson, M.D., Bay City
Luther R. Leader, M.D., Birmingham

Alternate Delegates to the American Medical Association (in order of seniority)—
Sidney Adler, M.D., Detroit
G. B. Saltonstall, M.D., Charlevoix
Bradley M. Harris, M.D., Ypsilanti
Lawrence A. Drolett, M.D., Lansing

DIRECTORY

1963 MSMS House of Delegates

Record of Attendance

	1st	2nd	3rd	4th	5th	6th
J. J. Lightbody, M.D., Speaker.....	X	X	X	X	X	X
John W. Rice, M.D., Vice Speaker	X	X	X	X	X	X
D. Bruce Wiley, M.D., Secretary...	X	X	X	X	X	X
Otto K. Engelke, M.D., Immediate Past President...	X	X	X	X	X	–
A. V. Wenger, M.D., Honorary Member	—	—	—	—	—	—
DELEGATES						
ALLEGAN						
Lewis F. Brown, M.D.....	X	X	X	X	X	X
ALPENA-ALCONA-PRESQUE ISLE						
John W. Bunting, M.D.....	X	X	X	X	X	X
BARRY						
Alexander B. Gwinn, M.D.....	X	X	X	X	X	—
BAY-ARENAC-IOSCO						
Wm. G. Gamble, Jr., M.D.....	X	X	X	—	—	—
Edward H. Rodda, M.D.....	X	X	X	—	X	—
BERRIEN						
Noel J. Hershey, M.D.....	X	X	X	X	X	X
Paul O. Rague, M.D.....	X	X	X	X	X	X
BRANCH						
Robert M. Leitch, M.D.....	X	X	X	X	–	X
CALHOUN						
George T. Kelleher, M.D.....	X	X	X	X	X	X
Keith S. Wemmer, M.D.....	X	X	X	X	X	X
Salvatore A. Yannitelli, M.D.....	—	—	—	—	—	—
CASS						
Uriah M. Adams, M.D.....	—	—	—	—	X	X
CHIPPEWA-MACKINAC						
Donald D. Finlayson, M.D.....	X	X	X	X	X	X
CLINTON						
Franklin W. Smith, M.D.....	X	X	X	X	X	X
DELTA-SCHOOLCRAFT						
Francis C. Anderson, M.D.....	X	X	X	X	X	X
DICKINSON-IRON						
Donald T. Anderson, M.D.....	X	X	X	X	X	—
EATON						
Byron P. Brown, M.D.....	X	X	X	X	X	X
GENESEE						
F. W. Baske, M.D.....	X	X	X	X	X	X
Lawrence G. Bateman, M.D.....	X	X	X	X	X	X
Wm. F. Buchanan, M.D.....	X	X	X	X	—	X
Clifford W. Colwell, M.D.....	X	X	X	X	X	X
H. Maxwell Golden, M.D.....	X	X	X	X	X	X
Phillip K. Stevens, M.D..	X	X	X	X	X	X
GOGEBIC						
John R. Franck, M.D.....	X	X	X	X	X	X
GRAND TRAVERSE-LEELANAU-BENZIE						
John R. Spencer, M.D.....	—	X	X	X	X	X
GRATIOT-ISABELLA-CLARE						
John M. Wood, M.D.....	X	X	X	X	X	X
HILLSDALE						
Luther W. Day, M.D.....	X	X	X	X	X	X
HOUGHTON-BARAGA-KEWEENAW						
Andrew M. Roche, M.D.....	X	X	X	—	X	X
HURON						
Charles S. Elliott, M.D.....	X	X	X	X	–	—
INGHAM						
Lawrence A. Drolett, M.D.....	X	X	X	X	X	X
Herbert W. Harris, M.D.....	X	X	X	X	X	X
D. Bonta Hiscoe, M.D.....	X	X	X	X	X	X
Mahlon S. Sharp, M.D.....	X	X	X	—	X	X
Robert M. Stow, M.D.....	X	X	X	X	X	X
IONIA-MONTCALM						
Robert E. Rice, M.D.....	X	X	X	X	—	—
JACKSON						
Harold L. Oster, M.D.....	X	X	X	X	X	X
Ross V. Taylor, M.D.....	X	X	X	X	X	X
KALAMAZOO						
W. Kaye Locklin, M.D.....	X	X	–	X	X	X
Don Marshall, M.D.....	X	X	X	X	X	X
Donald G. May, M.D.....	X	X	X	X	X	X
Frederick C. Ryan, M.D.....	X	X	X	X	X	X
KENT						
Noyes L. Avery, Jr., M.D.....	X	X	X	X	X	X
W. Clarence Beets, M.D.....	X	X	X	X	X	X
Frederick C. Brace, M.D.....	X	X	X	X	X	X
J. Russell Brink, M.D.....	X	X	X	X	X	X
James A. Ferguson, M.D.....	X	X	—	X	X	X
Leo J. Kenney, M.D.....	X	X	X	X	—	X
John R. Pedden, M.D.....	X	X	X	X	X	X
Allison R. VandenBerg, M.D.....	X	X	—	X	—	—
LAPEER						
James R. Doty, M.D.....	X	X	X	X	X	X
LENAWEE						
Donato F. Sarapo, M.D.....	X	X	X	X	X	–
LIVINGSTON						
Edwin S. Woodworth, M.D.....	X	X	X	X	X	X
LUCE						
Wm. R. Purmort, M.D.....	X	X	X	X	X	–
MACOMB						
Maurice S. Reizen, M.D.....	X	X	X	X	X	X
Sydney Scher, M.D.....	X	X	X	X	X	—
Edward G. Siegfried, M.D.....	X	X	X	X	X	X
MANISTEE						
Robert R. Garneau, M.D...	–	—	X	X	—	–
MARQUETTE-ALGER						
Eugene R. Elzinga, M.D.....	X	X	X	X	X	X
MASON						
Herbert G. Bacon, M.D.....	X	X	X	X	X	X
MECOSTA-OSCEOLA-LAKE						
Paul Ivkovich, M.D.....	X	X	X	X	X	X
MENOMINEE						
Herman R. Brukardt, M.D.....	X	X	X	X	X	X
MIDLAND						
Harold L. Gordon, M.D.....	X	X	X	X	X	X
MONROE						
S. Newton Kelso, Jr., M.D.....	—	X	X	X	X	X

	1st	2nd	3rd	4th	5th	6th
MUSKEGON						
Robert J. Fles, M.D.	X	X	X	X	X	X
H. Clay Tellman, M.D.	X	X	X	X	X	X
NEWAYGO						
J. Paul Klein, M.D.	X	X	X	X	X	X
NORTH CENTRAL						
Louis F. Hayes, M.D.	X	X	X	X	X	X
NORTHERN MICHIGAN						
Gerald A. Drake, M.D.	X	X	X	X	X	X
OAKLAND						
Robert M. Bookmyer, M.D.	X	X	X	X	—	X
Arnold L. Brown, M.D.	X	X	X	X	X	X
Edward E. Elder, Jr., M.D.	X	X	X	X	X	X
Harold A. Furlong, M.D.	X	X	X	X	X	X
Rodman C. Jacobi, M.D.	X	X	X	X	X	—
Paul T. Lahti, M.D.	X	X	X	X	X	X
Harry E. Lichtwardt, M.D.	X	X	X	X	X	X
James R. Quinn, Jr., M.D.	X	X	X	X	X	X
Vincent P. Russell, M.D.	X	X	X	X	—	—
OCEANA						
Clarence E. Diehl, Jr., M.D.	X	X	X	X	X	—
ONTONAGON						
William F. Strong, M.D.	X	X	X	X	X	—
OTTAWA						
John H. Kitchel, M.D.	X	X	X	X	X	X
SAGINAW						
Vernon V. Bass, M.D.	X	X	X	X	X	X
Hugh T. Caumartin, M.D.	X	X	X	X	X	X
Robert F. Powers, M.D.	X	X	X	X	X	X
ST. CLAIR						
Anthony C. Gholz, M.D.	X	X	X	X	—	—
James H. Tisdel, M.D.	X	X	X	X	—	—
ST. JOSEPH						
Stanley C. Penzotti, M.D.	X	X	X	X	—	X
SANILAC						
Keate T. McGunegle, M.D.	X	X	X	X	X	X
SHIAWASSEE						
Claude L. Weston, M.D.	X	X	X	X	X	X
TUSCOLA						
Lloyd L. Savage, M.D.	X	X	X	X	—	X
VAN BUREN						
Thomas J. Dillon, M.D.	X	X	X	X	X	X
WASHTENAW						
Gerhard H. Bauer, M.D.	X	X	X	X	X	X
Harold F. Falls, M.D.	X	X	X	X	X	X
L. Dell Henry, M.D.	X	X	X	X	X	X
John E. Magielski, M.D.	X	X	X	X	X	—
Beverly C. Payne, M.D.	X	X	X	X	X	—
Harry A. Towsley, M.D.	X	X	X	X	X	X
Charles J. Tupper, M.D.	X	X	X	X	X	X

	1st	2nd	3rd	4th	5th	6th
WAYNE						
Alfred H. Whittaker, M.D.	X	X	X	X	X	X
Robert K. Whiteley, M.D.	X	X	X	X	—	X
Ralph R. Cooper, M.D.	X	X	X	X	X	X
James B. Blodgett, M.D.	X	X	X	X	X	X
Sidney Adler, M.D.	X	X	X	X	—	X
Brock E. Brush, M.D.	X	X	X	—	—	—
Donald N. Sweeny, Jr., M.D.	X	X	X	X	X	X
Wyman C. C. Cole, Jr., M.D.	X	X	—	X	X	X
Jack Rom, M.D.	X	X	X	X	X	X
James D. Fryfogle, M.D.	X	—	X	—	X	X
Edward J. Tallant, M.D.	X	X	X	X	—	X
Paul J. Connolly, M.D.	X	X	X	X	X	X
Alexander Blain, III, M.D.	X	X	X	X	X	X
Milton R. Weed	X	X	X	X	X	X
William J. Yott, M.D.	X	X	X	X	X	X
Francis P. Rhoades, M.D.	X	X	X	X	X	X
George T. Bradley, M.D.	X	X	X	X	X	—
A. Hazen Priee, M.D.	X	X	X	X	X	X
John G. Slevin, M.D.	X	X	X	X	X	X
Louis Carbone, M.D.	X	X	X	X	X	X
George S. Fisher, M.D.	X	X	X	X	X	—
G. Thomas McKean, M.D.	X	X	X	X	X	X
Charles E. Darling, M.D.	X	X	X	—	—	—
Luther R. Leader, M.D.	X	X	X	X	—	X
Richard E. Wunsch, M.D.	X	X	X	X	X	X
Jacob F. Wenzel, M.D.	X	X	X	—	X	—
Edward M. Vardon, M.D.	X	X	X	X	X	X
Robert G. Swanson, M.D.	X	X	X	X	X	X
Arthur B. Levant, M.D.	X	X	X	X	X	X
James C. Danforth, Jr., M.D.	X	X	X	X	X	—
Elden C. Baumgarten, M.D.	X	X	X	X	X	—
Herbert W. Devine, M.D.	X	X	X	X	X	X
Louis J. Bailey, M.D.	X	X	X	X	—	X
William L. Brosius, M.D.	X	X	X	X	X	X
A. Jackson Day, M.D.	X	X	X	X	—	X
Joseph Hickey, M.D.	X	X	X	X	X	X
James J. Aiuto, M.D.	X	X	X	X	X	X
John R. Brown, M.D.	X	X	—	X	X	X
Frank S. Perkin, M.D.	X	X	X	—	X	X
Marjorie Peebles Meyers, M.D.	X	X	X	X	—	X
Max L. Lichter, M.D.	X	—	X	X	X	—
C. Jackson Francc, M.D.	X	X	—	X	X	X
Clement J. Pollina, M.D.	X	X	X	X	X	X
John W. Moses, M.D.	X	X	X	X	X	X
A. Zack Rogers, M.D.	X	X	X	X	X	X
Louis E. Heideman, M.D.	X	X	X	X	X	X
Mario A. Petrini, M.D.	X	X	X	X	X	X
Raymond J. Kokowicz, M.D.	X	X	X	X	X	X
Howard C. Rees, M.D.	X	X	X	X	X	X
William J. Coulter, M.D.	X	X	X	X	X	X
Elmer B. Miller, M.D.	X	—	X	X	—	—
Eli J. Igna, M.D.	X	X	X	X	X	X
E. Clarkson Long, M.D.	—	—	—	—	—	X
WEXFORD-MISSAUKEE						
Gregory P. Moore, M.D.	X	X	X	X	X	X
MEDICAL STUDENTS UNIVERSITY OF MICHIGAN						
Terry Chamberlain	X	—	—	—	—	—
James E. Fox	X	X	X	X	X	X
Harvey Gendler	X	X	X	X	—	—
Edwin J. Hammer	—	X	X	X	X	X
Thomas W. Reed	X	X	X	—	—	X
WAYNE STATE UNIVERSITY						
Daniel R. Barr	X	X	X	X	—	X
Harold Blumenstein	—	—	—	—	X	X
Woodrow Donovan	X	X	X	X	—	X
Ronald R. Larson	X	X	X	X	—	X
Gerald Moore	X	X	—	X	X	X
Leland B. Phelps	—	X	X	—	—	X

Reference Committee Personnel

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Franklin W. Smith, M.D., Clinton
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Wm. J. Yott, M.D., Wayne

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H. C. Hansen, M.D., Battle Creek

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J. J. Lightbody, M.D., Chairman, Wayne
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John W. Rice, M.D., Jackson
R. Wallace Teed, M.D., Washtenaw

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Robert K. Whiteley, M.D., Chairman, Wayne
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O. B. McGillicuddy, M.D., Lansing

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Milton R. Weed, M.D., Wayne

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H. H. Hiscock, M.D., Flint
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REPORTS OF STANDING COMMITTEES

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E. C. Baumgarten, M.D., Wayne
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Floyd B. Levagood, M.D., Wayne
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W. Kaye Locklin, M.D., Kalamazoo

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Harold F. Falls, M.D., Washtenaw
James D. Frvfogle, M.D., Wayne
Harold A. Furlong, M.D., Oakland

Councilor Advisor:
C. A. Payne, M.D., Grand Rapids

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Hugh M. Fuller, M.D., Wayne
S. Newton Kelso, Jr., M.D., Monroe

Councilor Advisor:
R. V. Daugherty, M.D., Cadillac

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James C. Danforth, Jr., M.D., Wayne
Councilor Advisor:
D. R. Smith, M.D., Iron Mountain

WAYS AND MEANS

Noyes L. Avery, Jr., M.D., Chairman, Kent
Alexander Blain, III, M.D., Wayne
Robert M. Bookmyer, M.D., Oakland
Wm. F. Buchanan, M.D., Genesee
Harold L. Gordon, M.D., Midland
Marjorie P. Meyers, M.D., Wayne
John W. Moses, M.D., Wayne

Councilor Advisors:
W. W. Babcock, M.D., Detroit
O. B. McGillicuddy, M.D., Lansing
C. A. Payne, M.D., Grand Rapids

New Books



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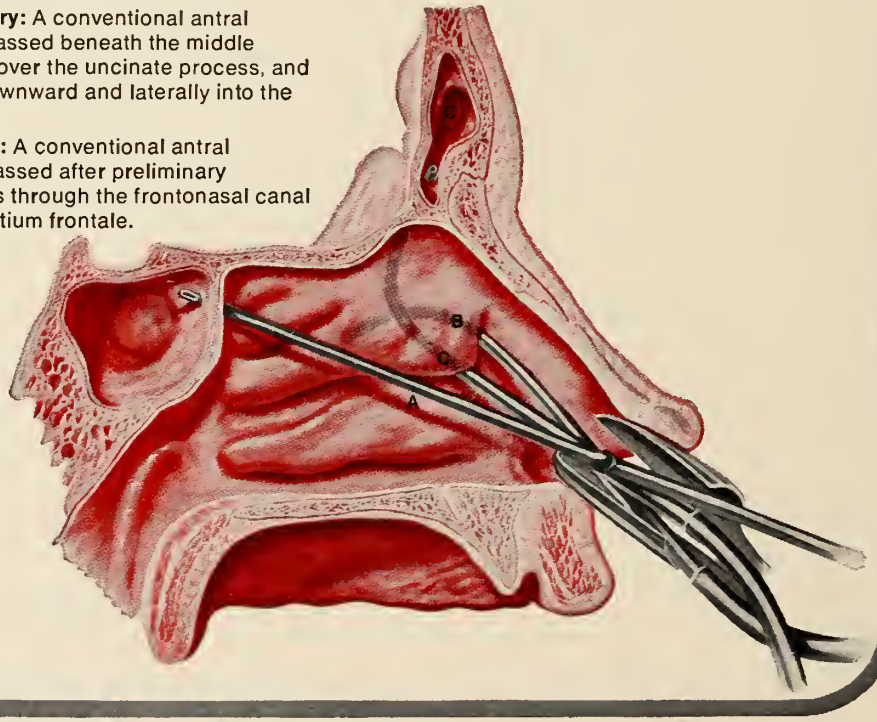
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February, 1964

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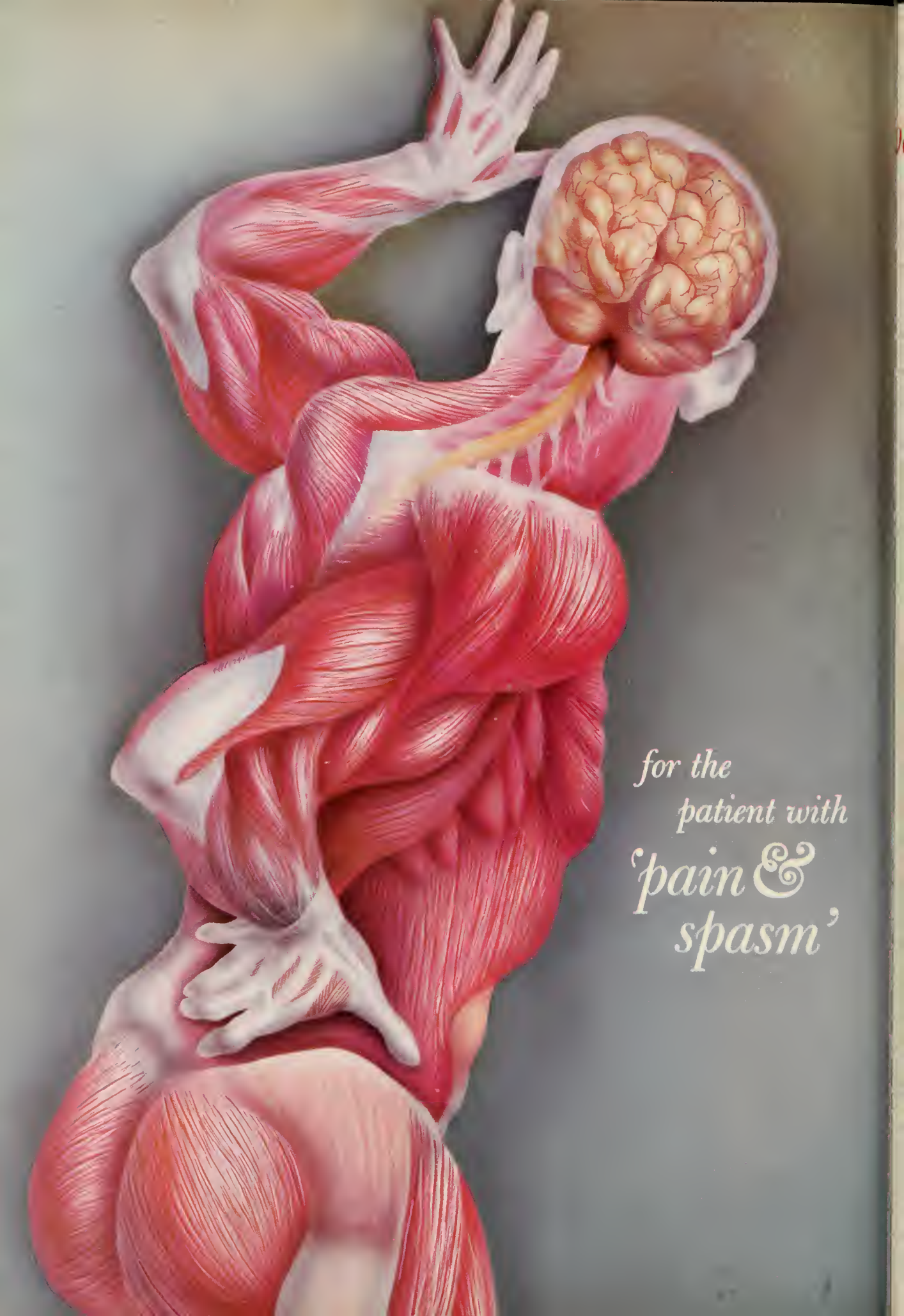
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President's Page

THOUGHTS ABOUT ETHICAL MATTERS



Arlen J. Johnson M. D.

President
Michigan State Medical Society

There has been very little change in the mechanism of settling differences between physicians and between physicians and patients. The establishment of local mediation or grievance committees was a good public relations development. They have dealt mostly with issues between patients and physicians related to fees. However, it is within the right, even the obligation of such committees to refer for ethical violations such deviations found in their deliberations. Whether or not this is done is obscure.

The inherent inadequacies of the current procedures are becoming evident with the inactivity in this area whereas there are indications there may be need for more.

The authority in medical organization arises from county societies. Only recently was there a breakthrough when the House of Delegates of the AMA accepted a recommendation of the Judicial Council permitting but little leeway by State Societies.

Governor Romney in addressing the House of Delegates of MSMS urged the society to act in such a manner as to remove criticism of conduct of physicians. What the specifics of the Governor's statement are is not known. That it is well meaning cannot be denied.

The first analysis indicates there have been many changes in the practice of medicine, professional and economic, which are not detailed in the code but are covered by general principles. Secondly, the mechanisms long in operation are ineffective or literally are not operating.

It may be that dependency on initial local actions should give way to a system of district committees or councils. To change the traditional procedure seems radical. To keep the present inactive, ineffective procedure is not meeting changed condition. The fundamental which must not be lost is judgment by our peers.

Come to Detroit For MCI, March 11-12-13



Recognizing the importance of continuing education, every MSMS member is urged to participate in the outstanding Michigan Clinical Institute, planned by the Michigan State Medical Society, for March 11-12-13 at the Sheraton-Cadillac Hotel, Detroit.

More than 1,000 doctors will attend the three-day postgraduate training program sponsored by MSMS and 10 cooperating medical organizations.

Timely topics will be discussed by recognized authorities during the MCI at the general assemblies, over the closed-circuit television, at the morning clinical roundtables and at the evening seminars. Exhibits also will add to the up-to-date knowledge of every doctor who attends.

* * *

The seven general assembly sessions will offer experts from Michigan, Virginia, Minnesota, California, Pennsylvania, Florida and Ontario. Among these out-of-state visitors will be such authorities as David A. Wood, M.D., San Francisco, a past president of the American Cancer Society.

* * *

Interested leaders of community organizations are invited to attend the two evening seminars. The program at 8 p.m., March 11, will deal with "Sex Education" and the March 12 seminar will consider, "When Our Parents Grow Old."

* * *

Eight ancillary events are scheduled during the MCI—including the Woman's Auxiliary and Medical Assistants as well as Operating Room Nurses, Chest Physicians, Plastic Surgeons, Neurosurgeons, and the alumni of the two Michigan medical schools.

* * *

The closed circuit, color television this year will originate at the Detroit Receiving Hospital. Each morning, these programs will be beamed into the Sheraton-Cadillac ballroom.

* * *

This year, the residents, interns and senior medical students are urged to attend the MCI on March 12. A special reception for them will be held in the late afternoon.

* * *

Outstanding Michigan doctors of medicine have been selected to conduct the Clinical Roundtables each morning from 8 to 9 a.m. Several of the visiting educators also will join the early-morning panels. The Roundtables provide the opportunity for MCI participants to ask specific questions on various subjects.

* * *

More information about the 1964 Michigan Clinical Institute—another service of MSMS for its members—can be found on Pages 114, 120, 129, 137.

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AMA Sees Court Action On IRS Proposal re Kintner

An Internal Revenue Service proposal, if finalized, will prohibit physicians and other professional men from receiving corporate tax treatment when they form associations with corporate characteristics.

Effect of the proposed regulation would be to abandon the so-called Kintner regulations of 1960 under which IRS stated that associations of professional men would be classified for tax purposes as corporations, provided state law authorized establishment of such groups as corporations.

Now, IRS says such professional organizations must have ALL the characteristics of a business corporation to qualify—and this is virtually impossible for professional men. Professional ethics, including such matters as personal liability, would bar a professional group from embodying all aspects of a business corporation.

AMA sources in Washington indicate that court litigation appears certain if the IRS proposal is made final.

MSMS Concerned Primarily About Bills in Six Fields

A State Legislature faced with reapportionment, charged with total reorganization of state government, and working toward an early adjournment deadline (mid-April) will have a record number of bills to consider! Nearly 1,500 proposals for new laws are in preparation. Among the proposed legislation now in process are MSMS endorsed bills to:

1. Repeal the Basic Science Act.
2. Up-date the present 1947 fee schedule in use by the Crippled Children Commission.
3. Require reporting of cases of child abuse, and provide immunity from liability.
4. License and regulate physical therapists.
5. Declare the transfusion of blood the provision of a service, not sale of a product.
6. Control over sale of paregoric.

County Secretaries—PR Seminar Slated February 27

To help make the work of the component county medical societies even more effective, an excellent program has been arranged for the 1964 Seminar February 27 at the Jack Tar Hotel in Lansing. The Seminar will open at 9:30 a.m. and close at 5:00 p.m.

Invited to participate are the following from each component county society—President, President-Elect, Secretary, Public Relations Committee Chairman, Legislative Committee Chairman, Editor, Operation Hometown Committee Chairman, and Executive Secretary.

Several meetings will be held the night before, February 26, at the Jack Tar Hotel. In session will be the MSMS Legal Affairs Committee and Public Relations Committee. Workshops will be held for all newly-elected county society secretaries and county society bulletin editors. All doctors attending these sessions will be urged to stay for the Seminar, February 27.

MSMS Annual Session Draws Doctors From Across State

The 1963 Annual Session of the Michigan State Medical Society drew doctors from 210 communities to Grand Rapids. The statistics illustrate without a doubt the effectiveness of the excellent scientific program in attracting busy practitioners from across the state.

A total number of 1,587 physicians attended, with members of the Woman's Auxiliary, members of the Michigan State Medical Assistants Society, nurses, technicians, students, and others running the grand total to 2,988. There were 43 doctors registered from outside of Michigan, including several visitors from Canada and Egypt.

The largest number of doctors from any one community was the host community of Grand Rapids with 332. Detroit rated second with 193, followed by Kalamazoo with 97, Flint 70, Ann Arbor 65, Lansing 60, Muskegon 55 and Saginaw 45.

Among the cities with between one and 39 doctors participating were Battle Creek, Bay City, Birmingham, Cadillac, Dearborn, East Lansing, Holland, Jackson, Midland, Pontiac, Royal Oak and Traverse City.

The specialties were represented as follows:

Specialty	*Michigan M.D.s Outside Wayne County*	*Wayne County M.D.s*
Anesthesiology	25	1
Dermatology-Syphilology	15	4
Gastroenterology-Proctology	7	3
General Practice	227	163
Medicine	114	18
Nervous & Mental	50	7
Obstetrics-Gynecology	81	13
Occupational Medicine	15	11
Ophthalmology	20	3
Otolaryngology	10	1
Pathology	21	5
Pediatrics	60	15
Public Health	36	—
Radiology	26	3
Surgery	142	25
Urology	17	7
Resident & Intern	95	21
Not Listed	205	80
TOTALS	1164	380

HIGHLIGHTS of The Council

Meeting of November 20, 1963

At its all-day meeting, The Council considered many matters, received reports, and reviewed minutes of many MSMS and Council committees. Highlights of items considered were the following:

- The Council reaffirmed the agreement reached between representatives of MSMS and the Michigan Hospital Association on January 22, 1939, that "the professional services of a doctor of medicine shall not be included in group hospital service programs." The Council also requested the Board of Trustees of the Michigan Hospital Association to define clearly and precisely those services which it regards as hospital services as distinguished from professional services of doctors of medicine.
- The Michigan Health Commissioner reported on medical certification for marriage licenses, anticipated federal grants for mental retardation prevention, civil defense, immunization, Cornell Auto Injury Study and the federal vaccination assistance act. The Council also received a report from the chairman of the MSMS Delegation to the AMA, following a luncheon caucus of the MSMS Delegation.
- E. E. Martmer, M.D., Detroit, was appointed General Chairman of Arrangements for the 1964 Annual Session.
- Plans were approved for holding the Annual County Secretaries-Public Relations Seminar on February 27, 1964, at the Jack Tar Hotel, Lansing.
- Craig E. Booher, M.D., Grand Rapids, was appointed Chairman for the 1964 Residents-Interns-Senior Medical Students Conference to be held coincident with the Michigan Clinical Institute in March.
- The statement of MSMS before the Ways and Means Committee, House of Representatives, Congress of the United States, was reviewed. The Council instructed that the MSMS testimony be sent to all Michigan representatives and senators in Washington.
- Regarding reorganization of state government, The Council reviewed progress in development of proposed MSMS policy and recommendations.
- By letter, Governor Romney expressed appreciation to MSMS and its House of Delegates for the award presented to him and the opportunity to speak to the House at its September meeting.
- Items referred to The Council by the 1963 House of Delegates were reviewed by The Council and appropriate action was taken to begin implementation of the instructions contained in the fourteen specific items.
- A progress report on the Michigan Health Fair was made by Health Fair Arrangements Committee Chairman Don W. McLean, M.D., who reported that following discussion regarding dates for the Health Fair with prospective exhibitors and school officials it was the Committee's recommendation that the Fair be put forward into the spring of 1966. This would provide eight months of work with school faculties to adequately prepare them and the students for the Health Fair. The dates recommended, April 30 through May 8, 1966, were approved by The Council.
- Regarding the Centennial Annual Session of MSMS in September, 1965, The Council authorized execution of a contract with Cobo Hall.
- The Council received a report on Michigan Mental Health Leadership Conference, sponsored by MSMS with the Michigan Society for Mental Health, at Kellogg Center, October, 1963. The report was made by Benjamin Jeffries, M.D.
- Report on Midwestern Workshop on Medical Aspects of Driver Licensure, September, 1963, Chicago, was received from Carl M. Hanson, M.D.
- MSMS Legal Counsel Lester P. Dodd reported on opinions regarding admissions and treatment of patients, delegation of function by physician, liability in mass inoculation programs, standards of practice.
- The Council, upon recommendation of the Finance Committee, instructed that the matter of proposed state legislation re declaration of transfusion of blood and blood products as a service rather than a product be referred to the Legal Affairs Committee for consideration and implementation.
- Mr. Brenneman submitted several recommendations for The Council's consideration and reported on the success of the Community Health Week program, which was conducted throughout the state with the cooperation of the Michigan Health Council, the Michigan Association of the Professions and MSMS.
- Mr. Burns provided a detailed report of the functioning of the MSMS headquarters and staff.
- Committee reports—The following minutes were reviewed:
- Hospital Relations Committee, meeting of August 14,

(Continued on Page 88)



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HIGHLIGHTS OF THE COUNCIL MEETING OF NOVEMBER 20, 1963

(Continued from Page 86)

1963. The minutes reviewed the code of procedures and ethics relating to autopsies, the policy of Michigan Hospital Association re questionnaire to member hospitals, physician membership on hospital governing boards, proposed new pharmacy rules and regulations and hospital study commission for publicly operated hospitals. This Committee was instructed by The Council to request a meeting with the State Board of Pharmacy and other appropriate groups prior to the promulgation of new Board rules, in order that the September action of The Council can be effectively reported and interpreted to the Board.

- Mental Health Committee, meeting of September 5, 1963. These minutes reported the success of the State-County Mental Health Conference, discussed plans for a state congress on mental health and mental illness and reviewed implementation of state community mental health services legislation, discussed the Department of Mental Health under the new Constitution, and reviewed the status of the Department of Mental Health Planning Project. Subsequently, The Council authorized the expenditure of up to $700 for the sponsorship of a state congress on mental health and mental illness. The Chairman of the Legal Affairs Committee and the Chairman of the Mental Health Committee were authorized to be present at December hearings on mental health in Lansing.
- Professional Insurance Plans Committee, meeting of September 11, 1963. These minutes reviewed correspondence from individual MSMS members concerning insurance coverage, reported progress in development of major hospital coverage for MSMS members, discussed health insurance pooling.
- Professional Insurance Plans Committee, meeting of October 17, 1963. These minutes recommended a major hospital proposal for MSMS members from Health Service, Incorporated. The Council rereferred the matter to the Committee to determine if the benefits of the proposal are in accordance with MSMS policy that professional services of doctors of medicine shall not be included in group hospital service programs.
- Professional Insurance Plans, meeting of October 30, 1963. These minutes recommended that MSMS move towards a single disability plan for all members of MSMS and Wayne County Medical Society. A proposal for such expanded disability protection was adopted, and will be referred to Wayne County for consideration. The Council approved a committee recommendation to accept an offer from Provident

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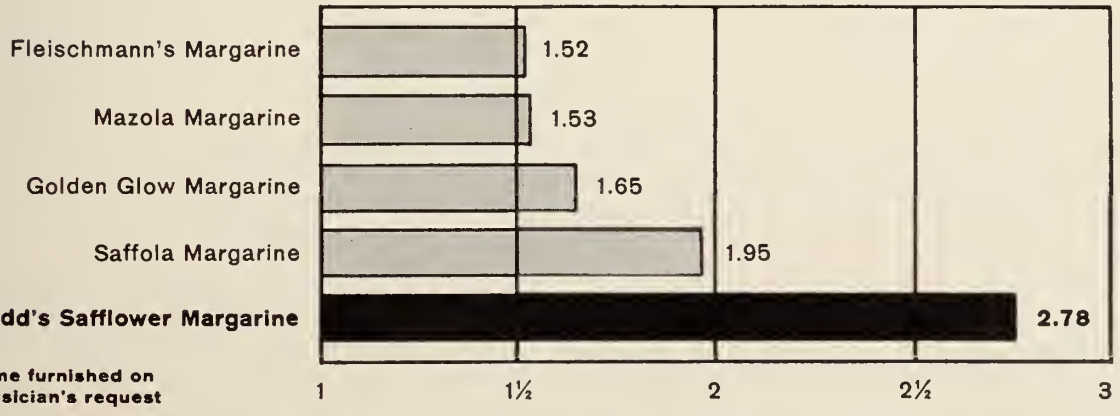


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HIGHLIGHTS OF THE COUNCIL MEETING OF NOVEMBER 20, 1963

(Continued from Page 88)

Life and Accident Insurance Company to immediately improve the MSMS group disability program; and also to offer MSMS members a high limit personal accident insurance policy.

- 1964 MCI Television Committee, meeting of September 10, 1963. These minutes reported development of the closed-circuit color television program for March, 1964.
- Advisory Committee of Past Presidents, meeting of September 26, 1963. These minutes discussed the centennial celebration of MSMS and made a recommendation regarding the induction of the MSMS president. This recommendation was referred to the Speaker of the House of Delegates.
- Diabetes Control Committee, meeting of October 2, 1963. These minutes reviewed the Michigan Diabetes Association role in the 1963 Diabetes Detection Drive and made certain recommendations re MSMS participation. Upon recommendation of the Finance Committee, The Council approved the contribution of $200 toward the detection program.
- Geriatrics Committee, meeting of October 9, 1963. These minutes reviewed plans for the geriatrics seminar during the 1964 MCI, the Michigan Commission on Aging Saginaw County activity, and AMA Commission on Aging activity.
- Maternal Health Committee, meeting of October 10, 1963. These minutes reported progress in the development of Desk Reference Card No. 2 on Septic Abortion, reviewed subcommittee report on perinatal mortality, maternal mortality and lay education.
- 1964 MCI Program Committee, meeting of October 30, 1963. These minutes reviewed development of the 1964 MCI program and clinical roundtables, and arrangements for the evening seminars.
- Advisory Committee to the Executive Director, meeting of October 30, 1963. Chairman O. J. Johnson, M.D., reported progress in development of a new staff organization by the new Executive Director, Associate Executive Director and Professor Clyde Hardwick, as directed by the Advisory Committee.
- 1964 Annual Session Program Committee, meeting of November 6, 1963. These minutes reviewed the success of the 1963 Annual Session in Grand Rapids and discussed plans for cooperation with sections at the 1964 Annual Session, outlined development of the assembly program and reported offers of support for speakers. The Council appointed an ad hoc committee to study the location of the 1966 and 1967 Annual Sessions.
- Committee on Highway Accident Prevention, meeting of October 24, 1963. These minutes contained a report from the Michigan State Safety Commission, report from the Michigan Department of State, review of 1963 state legislative proposal, report on Washtenaw County Accident Study and report on AMA Workshop on Driver Licensure. The minutes recommended Council endorsement of the incorporation of certain language in any Michigan law on chemical testing for intoxication. The Council adopted proposed language.

Welcome, New Members

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(Continued on Page 92)

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Royal Oak, Michigan

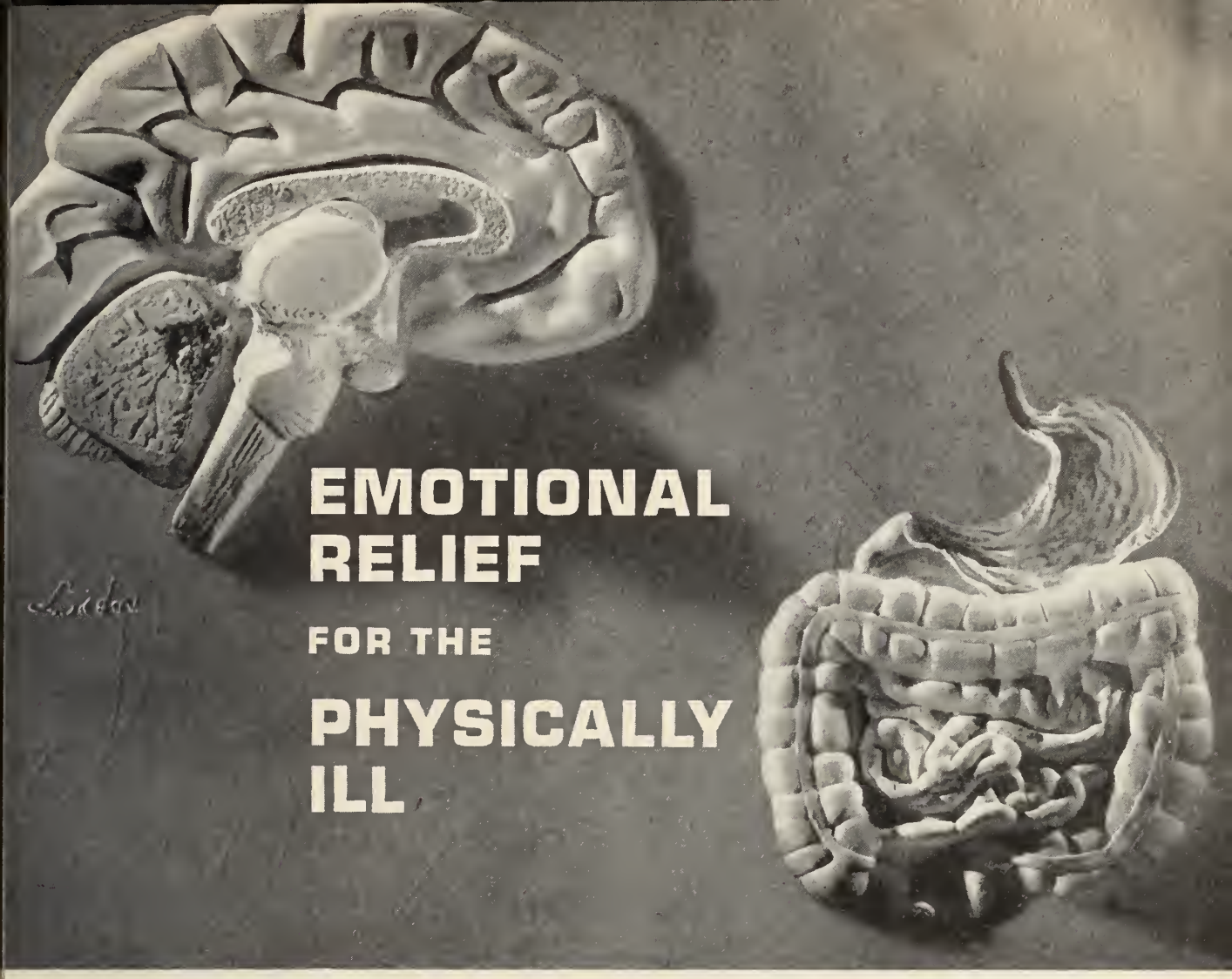
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D. Eugene Garrison, M.D.
587 Rosemont
Saline, Michigan

Robert T. Goldman, M.D.
Wayne County General Hospital
Eloise, Michigan
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(Continued from Page 90)

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AN IMPORTANT MESSAGE TO DOCTORS FROM BLUE SHIELD

RE: — *NEW REPORTING PROCEDURES*

Blue Shield's new reporting procedures adapted in the interest of increased administrative efficiency and described to you in our letter of October 4, 1963, have necessitated a review and detailed explanation of the rules governing the reporting of doctor's service claims.

This review was done by a specially formed, six-member *ad hoc* committee appointed by the Board of Directors, the Committee to Investigate and Facilitate Payments to Physicians.

In the course of this review the Blue Shield Committee met with Michigan Hospital Association's Hospital Relations Committee. Members of the M.H.A. Committee were supplied with copies of the revised rules and are now considering their implementation by M.H.A. members. The Hospital Relations Committee indicated that it will forward to Blue Shield by January 15th a letter containing its recommendations for instituting our new rules.

On the basis of this agreement, Blue Shield has extended to February 1, 1964, the effective date for total implementation of the new procedures by hospitals.

A copy of the rules and detailed reasons for their adoption is a part of this message. These rules and the reasons for their adoption were sent to you, via the mails, on December 23. They are reprinted here, for your convenience, to cover the eventuality that some letters may have gone astray during the Holiday mailing confusion.

Thank you for your continued co-operation. We appreciate your efforts in helping us to effect these changes so smoothly and rapidly.

Sidney Adler, M.D.
President

MESSAGE ON NEXT 3 PAGES

Say you saw it in the Journal of the Michigan State Medical Society

An Important Message to Doctors From BLUE SHIELD.

Rules Governing the Reporting and Payment Mechanisms of Michigan Medical Service

I. RULE

The medical service being reported shall be described in such manner as to preserve to Michigan Medical Service the right to categorize the service into a price-determining procedure.

REASON

Michigan Medical Service has the non-delegable responsibility to translate the description of services into its price-determining procedure, nomenclature and code. This is necessary to provide consistency and equity of payment.

Further, centralization of office work permits uniformity in the accounting categorization of disbursements and greater specialization in office personnel.

To be specifically noted is that the complexities of the Michigan Medical Fee Schedule require personnel trained in the above-mentioned translations.

II. RULE

Each reported service must be identified with the physician who performed that service.

This physician must certify a statement attesting to the fact that he personally performed the service identified as being rendered by him.

REASON

Because, by contract, Michigan Medical Service may pay only for services rendered by or under the supervision of a licensed physician, it is essential that each performer of service be identified, thus providing the corporation with a method of verifying the fact that the performer of service is, in fact, a licensed physician.

As proper stewards of the money entrusted to them, it is essential that Michigan Medical Service be assured in a legal manner that each service considered for payment be attested to by the person rendering service.

Further, the purpose of cost-control techniques is the accumulation and study of all expenses, in order to plan and control the total business operation. These are specifically the actuarial, underwriting and utilization-audit functions of Michigan Medical Service as a prepayment organization. To successfully carry out such functions, it is essential that each doctor be specifically identified with the service he performs and reports to Michigan Medical Service.

III. RULE

Michigan Medical Service defines a "performed service" as one the physician has personally rendered, or one that was rendered under his personal supervision and in his presence.

Say you saw it in the Journal of the Michigan State Medical Society

Michigan Medical Service will not pay for services rendered by residents, internes, or physicians in training.

REASON

The Michigan Medical Service contract specifies the above ruling. It is the position of Michigan Medical Service that the services of residents, internes and physicians in training are for the purpose of training manpower in the medical profession, opposed to rendering medical services, and that this training entails proper supervision.

IV. RULE

Michigan Medical Service will pay only for services in cases where the physician has a right to bill.

REASON

Michigan Medical Service's obligation is measured by the Enabling Act and the contract issued to its subscribers. If Michigan Medical Service does not contract to pay for the service, the obligation does not exist unless imposed by statute or unless voluntarily assumed in individual cases by Blue Shield.

A staff-patient or teaching-case-patient does not engage as such a staff or volunteer physician. There is therefore, no express contract between the patient and one physician, whereby the physician undertakes to serve the patient and the patient to compensate the physician. Neither is there any contract implied in fact or in law under which the patient became obliged to compensate such a physician; the patient's contractual liability runs exclusively to the hospital. Assignments executed by such physicians add nothing because the patients owe them no debt which they might assign.

V. RULE

The person to whom each service is rendered must be identified to the satisfaction of Michigan Medical Service. Further, the date and site of each service must also be identified; that is, in-patient and out-patient departments of a specified hospital, doctor's office, or other.

REASON

The above rule of action enables Michigan Medical Service to verify that the patient receiving service is covered by a Michigan Medical Service contract and that the service performed is a benefit of the contract then in force.

Further such a reporting requirement simply follows two of the basic principles of any effective records system: (1) Essential information should be presented simply, yet completely and accurately, and (2) Record systems should be designed for multiplicity of use. A source-document with the above-mentioned reporting requirements provides completeness and multiplicity of use of records, providing Michigan Medical Service with necessary cost-control data.

VI. RULE

No service reported to Michigan Medical Service will be considered for payment unless it has actually been performed. No service shall be considered by Michigan Medical Service on the basis of its contemplation regardless of any degree of probability that it will be



performed.

REASON

By contract, the physician is to report only such services as have been rendered to the subscriber or member.

Further, few individuals or businesses pay for services in advance. This is particularly true in those areas where the mere fact of reporting might result in unnecessary performance and/or the actual performance could vary considerably from the services reported.

VII. RULE

Michigan Medical Service shall advise all subscribers of both the physician and site of specific services rendered on their behalf. Such notice of payment will consist of a notice that full service benefits have been afforded or notice of the specific dollar amount.

REASON

The Michigan Medical Service contract is with the subscriber, and the corporation's fundamental accountability is to the subscriber.

Further, this is sound business practice, an additional safeguard of subscriber funds, and an aid to our subscriber. In many cases, it is essential that the subscriber know of payment so that he may satisfy business and accounting needs of his own. Again, this notification to the subscriber serves as a potent device for the detection of unperformed services that have been reported for payment either erroneously or by intent. Finally no business can survive without basic customer good will. The notification to the subscriber fosters this intangible but nevertheless real and necessary condition for carrying on business.

VIII. RULE

Michigan Medical Service considers only the doctor rendering the service or its subscriber to have the right to payment.

REASON

The contract restricts payment to the doctor rendering service or to the subscriber receiving it.

IX. RULE

Only those service reports compatible with the Blue Shield system and mechanism will be considered for payment.

REASON

An effective record system requires that standard formats be designed to fit the special needs of the company so that data may be logically arranged for easy interpretation and compilation. This is especially important when source-documents function in an automatic data-processing system and tie into filing methods designed for speed and accessibility.

Further, it is essential that claims reported to Michigan Medical Service be reported in a manner totally compatible with the Blue Shield system, because any inefficiency is a waste that channels subscriber's dollars away from health-care into needless correction or verifying activities.

Oakland County Society Develops Own Library

By Hazen L. Miller, M.D.

Birmingham



In February 1959, the donation of $300 to the Oakland County Medical Society by a Pontiac pharmacist, Thomas C. Fitzpatrick, resulted in a unique library. The collection started by this fund takes in several categories of a non-technical nature. There are a few rare and old technical books, collector's gems, which may have acquired value as antiquities or which may have special historical value.

Most of the Oakland County Medical Society Library are books on the history and philosophy of medicine, biographies of and by doctors and essays touching upon the art and science of the profession.

The collection has been enhanced by contributions from members and also notably from William J. Stapleton, Jr., M.D., and Alfred H. Whittaker, M.D., both of Detroit. We are constantly watching to make sure valuable books from the libraries of deceased members do not get into the hands of the junk dealer.

An annual allotment of two hundred dollars sustains the library. It has grown to nearly three hundred volumes. These include the archives of the society, the bound volumes of its Bulletin and various reference books for the benefit of the doctor who would write well.

* * *

THE LIBRARY COMMITTEE has been guided in its acquisitions by lists such as Stapleton's annual "100 Books for the Doctor" and by publishers' catalogs. Collecting thus gradually and with discrimination has not been a problem. This function of a library has been and can be met by any society so wishing.

Brisk and ready circulation of the library's books, the other and more important function, challenges the resources and ingenuity of its promoters. We find it cannot be done by the uninterested help in the Society's headquarters.

* * *

FROM OUR EXPERIENCE, we recommend that catologing, distribution of lists of books and other advertisements of the facilities of the library be in the hands of members of the Women's Auxiliary who have some training as librarians and are interested in making the library useful.

The potential of a well-selected library is so great that anyone instrumental in making it available may well stand in awe of what he has wrought. That which advances the ideals and principles of a profession belongs close to its heart. Adding machines, files, type-

writers and telephones have their place, but only a secondary one to that which elevates us above money-grubbing.



The Library at the headquarters of the Oakland County Medical Society is growing in popularity with the members and "challenges the resources and ingenuity of its promoters."

Mason County Society Honored by March of Dimes

The Mason County Medical Society recently received a "Certificate of Appreciation" from the Mason County March of Dimes. Officials of the Mason County March of Dimes have pointed out that the work of the physicians "was greatly instrumental in making the Mason March of Dimes campaign the most successful in its history." John Carney, M.D., accepted the certificate on behalf of the county society.

Genesee County to Present Cancer Day, April 15

After two years, the Genesee County Medical Society is again presenting an all-day program on cancer, Wednesday, April 15. As in the past, the program is being sponsored by the Whiting Foundation.

Six formal presentations will be given by outstanding authorities in the field. These are: Gilbert H. Fletcher, M.D., and William S. MacComb, M.D., both of the M. D. Anderson Hospital in Houston, Texas, who will present a combined surgical and radiotherapy approach to the treatment of head and neck lesions. Michael Deddish, M.D., Memorial Center, New York, will present a paper on cancer of the colon. David A. Karnofsky, M.D., of the Sloan-Kettering Institute of Cancer Research, will discuss current developments in chemotherapy and their significance. Michael B. Shimkin, M.D., of Fels Research Institute, Philadelphia, Pa., will talk on epidemiology of cancer. Samuel G. Taylor III, M.D., Presbyterian-St. Lukes Hospital, Chicago, will discuss management of breast cancer from biopsy to necropsy.

All members of the medical profession throughout the state of Michigan are invited to attend. More detailed information will be made available at a later date.

Berrien Student Loan Fund Going into Operation

The Berrien County Medical Student Loan Fund has approved its first qualified candidate for a loan. The application is now being processed. The student is a sophomore medical student at the University of Michigan from Benton Harbor.

The Berrien loan fund has close to $2,000 available for qualified medical students.

Doctors Sponsor Howell Scout Post

The medical staff at McPherson Community Health Center, Howell, is sponsoring an Explorer Post specializing in medicine. The boys will cover various aspects of a medical career—vocational, social, service, citizenship. Active on the organizational committee are Stanley Hoffman, M.D., L. E. May, M.D., Roscoe V. Stuber, M.D., and Edwin Woodworth, M.D., all members of the Livingston County Medical Society.



NEW VICE SPEAKER—Following the election by the 1963 House of Delegates at Grand Rapids, Louis F. Hayes, M.D. *(right)*, Gaylord, the new Vice Speaker, was introduced to the delegates by James J. Lightbody, M.D., Detroit, who was re-elected Speaker.



In Chronic Illness: B and C vitamins are therapy

An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS, containing therapeutic quantities of vitamins B and C, is formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

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7514-4

ARTHRALGEN® helps fre



ARTHRALGEN®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

Arthralgen, a better-tolerated analgesic formulation of time-tested ingredients, works faster to free the arthritic from his pain without salicylate side effects. Since its analgesic components require no chemical conversion to act in the body, Arthralgen's pain relieving benefits are immediately available to provide a smoother, more rapid obtundation of pain than can be achieved with many true salicylates.

Arthralgen is especially useful for the prompt relief of early morning stiffness and pain with less risk of gastric irritation. And since Arthralgen contains no sodium it is safe for long-term use in arthritics who have other conditions which nece sitate sodium restriction.

ARTHRALGEN®-PR

Each tablet contains:

Salicylamide	250 m
Acetaminophen	250 m
Ascorbic acid (Vitamin C)	25 m
Prednisone	1 m

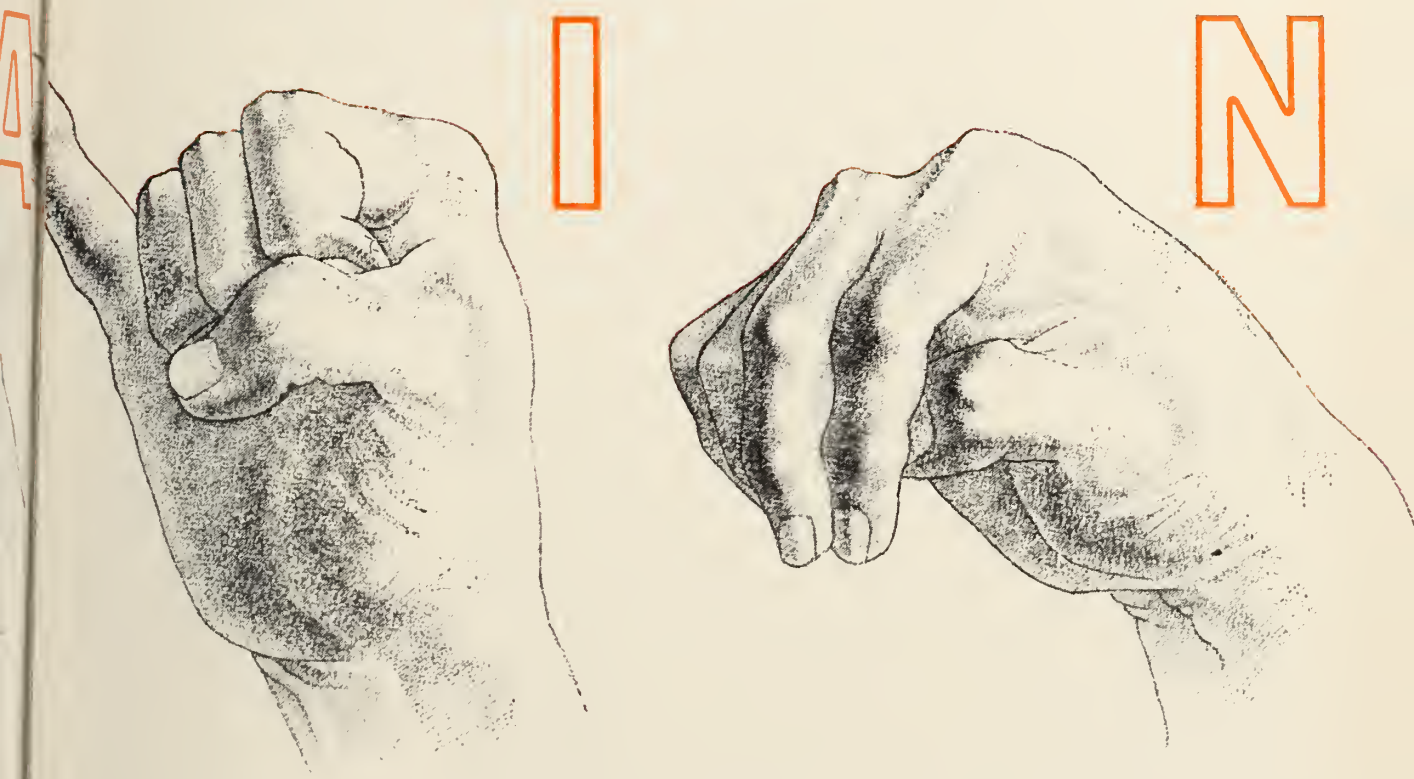
The basic Arthralgen formulation plus predni sone is indicated for patients who require steroid. Prednisone has three advantages over cortison hydrocortisone, and ACTH. They are: (1) lack sodium retention, (2) absence of increased pota sium excretion, and (3) the unlikelihood of steroi induced hypertension.*

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated i the management of rheumatoid arthritis, acut

Say you saw it in the Journal of the Michigan State Medical Society

rthritic joints from



uty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and rious myalgias.

OSAGE: One or two tablets four times a day. fter remission of symptoms, dosage should be duced to the minimum maintenance level.

DE EFFECTS: Nausea, GI upset, or mild salicysm may rarely occur. Symptoms of hypercorticoidm dictate reduction of dosage of Arthralgen-PR.

RECAUTION: Reduction in dosage of Arthralen-PR given over a long period should be gradual, ever abrupt.

ONTRAINDICATIONS: Hypersensitivity to any ngredient.

s with any drug containing prednisone, Arthralen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

A. H. ROBINS CO., INC.
RICHMOND, VIRGINIA

Say you saw it in the Journal of the Michigan State Medical Society



When you prescribe for nasal congestion...

remember 'Empirin' Compound to relieve common cold discomfort



Also: 'Empirin'® Compound with Codeine Phosphate*
gr. ⅛—No. 1/gr. ¼—No. 2/gr. ½—No. 3/gr. 1—No. 4
*Warning—may be habit forming

New Statistics Released on Consumer Expenditures for Medical Care

By Richard M. Campau
MSMS Research Director

The Social Security Administration has just reported the following data on Private Consumer Medical Care Expenditures:

PRIVATE CONSUMER EXPENDITURES FOR MEDICAL CARE[1]

Type of Expenditures	*1961*	*1962*
	Amount (in millions)	
Total	$20,749	$21,945
Hospital care	5,667	6,098
Physicians' services[2]	5,577	5,823
Dentists' services	2,108	2,202
Drugs and drug sundries[3]	4,016	4,157
Eyeglasses and appliances[4]	1,247	1,372
Other professional services[5]	851	887
Nursing home care	305	346
Health Insurance, net cost[6]	978	1,060
	Percentage Distribution	
Total	100.0	100.0
Hospital care	27.3	27.8
Physicians' services	26.9	26.5
Dentists' services	10.2	10.0
Drugs and drug sundries	19.4	18.9
Eyeglasses and appliances	6.0	6.3
Other professional services	4.1	4.0
Nursing home care	1.5	1.6
Health insurance, net cost	4.7	4.8

[1]Includes all government and private employer contributions for health insurance of employees but excludes workmen's compensation payments for medical benefits and all medical payments under public programs. Data exclude Puerto Rico, the Virgin Islands and Guam.
[2]Services of medical and osteopathic physicians in solo and group private practice and in consumer-sponsored group clinics.
[3]Includes surgical supplies.
[4]Includes fees of optometrists and expenditures for hearing aids, orthopedic appliances, artificial limbs, crutches, wheelchairs, etc.
[5]Services of registered and practical nurses in private duty, visiting nurses, podiatrists, physical therapists, clinical psychologists, chiropractors, naturopaths, and Christian Science practitioners.
[6]Difference between income and benefit expenditures of all health organizations.

The foregoing chart shows the following interesting trends:

Consumer medical care expenditures amounted to $21.9 billion in 1962, a rise of $1.2 billion from the amount spent in the preceding year. Hospital care expenditures increased 7.6 per cent during 1962 to $6.1 billion. Expenditures for the services of all practitioners—physicians, dentists, and others—rose approximately 4.0-4.5 per cent. Amounts spent for drugs and drug sundries, representing almost a fifth of the medical care dollar, increased only 3.5 per cent. The largest relative increase—13.4 per cent—was reported in expenditures for nursing-home care, where per diem costs and utilization of facilities continue to rise at a rapid rate. The 10 per cent increase in expenditures for eyeglasses and appliances, including fees of optometrists, was the largest percentage increase in several years.

The net cost of obtaining health insurance, that is, the difference between premiums and benefit expenditures of health insurance organizations, amounted to $1.1 billion—4.8 per cent of the total health care bill in 1962. This amount represents the total retentions of health insurance organizations for acquisition and other administrative expenses, premium taxes, additions to reserves, and profits, and it was 8.4 per cent higher than the amount retained for these purposes in 1961.

Medical Care Dollar

Other information made available by the Social Security Administration reveals that since 1948 there has been an increase in the share of the medical care dollar going for hospital care, and a decrease in the proportion going for physicians' and dentists' services. The following chart gives the distribution of the medical care dollar in 1948 and 1962.

THE MEDICAL CARE DOLLAR

$1.00 in 1948		$1.00 in 1962
22 cents	Hospital Care	28 cents
33 cents	Physicians' services	27 cents
12 cents	Dentists' services	10 cents
19 cents	Drugs	19 cents
14 cents	All Other	16 cents

Materials for the Medical Socio-Economic Section are provided by Richard M. Campau, MSMS Research Director.

Health Insurance Coverage Jumps in Past Decade

Health insurance protects 50 million more Americans today than it did 10 years ago. The Health Insurance Institute reports that 10 years ago, only 91 million Americans were covered by hospital expense insurance but now a total of over 141 million

persons were protected against the costs of hospital care at year-end 1962.

In 1952, 59 per cent of the U. S. civilian population were protected by some form of health insurance, the Institute said, while at the beginning of this year 76 per cent of Americans were so covered.

Health Insurance Tabulations Reveal Trends in Coverage

The just published 1963 "Source Book of Health Insurance Data" reveals the following significant trends in health insurance coverage as of the end of 1962:

Hospital expense insurance:
141,437,000 persons, up 3.6 per cent over 1961.
Surgical expense insurance:
131,185,000 persons, up 3.3 per cent over 1961.
Regular medical expense insurance:
98,204,000, up 4.2 per cent over 1961.
Major medical expense insurance:
38,250,000, up 12.0 per cent over 1961.
Loss-of-income insurance:
44,902,000 wage earners, up 4.3 per cent over 1961.

This coverage was provided by 1,827 insuring organizations as follows:

Insurance Companies	879
Blue Cross Plans	77
Blue Shield Plans	71
Other Health Care Plans	800
	1,827

These same organizations paid out a record total of $7,077,000,000 in benefits to insured persons in 1962, including $906 million toward the replacement of income lost through disability. Total health insurance benefits rose 10.6 per cent over 1961.

284 Firms in Michigan Provide Health Insurance

At the end of 1962, over 1,800 insuring organizations (including 284 in Michigan) provided the American public with health insurance for the hospital, surgical, and medical expense resulting from injury or illness and for loss of income accompanying such disability.

The Health Insurance Institute reports the net total of persons with health insurance provided by these organizations was 141,437,000 at the close of last year. Some $7.1 billion in health insurance benefits were distributed among these insured persons during 1962.

The Institute also reports that from 1952 to 1963, there was a 71 per cent increase in the over-all number of insurance companies writing health insurance.

Social Security Tax Bite Climbs Higher

Following is a summary of the growth of the Social Security tax since its inception, and also covers the project rates under the King-Anderson proposal:

Years	*Tax Rate*	*Annual Taxable Wage Base*	*Employee/ Employer Annual Cost**
1937-49	1 %	$3,000	$ 30.00
1950	1½%	$3,000	$ 30.00
1951	1½%	$3,600	$ 54.00
1954	2 %	$3,600	$ 72.00
1955	2 %	$4,200	$ 84.00
1957	2¼%	$4,200	$ 94.50
1959	2½%	$4,800	$120.00
1960	3 %	$4,800	$144.00
1962	3⅛%	$4,800	$150.00
1963	3⅝%	$4,800	$174.00
	—Increases Called For Under Existing Law—		
1966	4⅛%	$4,800	$198.00
1968	4⅝%	$4,800	$222.00

*Calculated on maximum taxable wage base.

If the King-Anderson bill is enacted, a further increase would be necessary to finance the system.

The tax rate by 1968 would have to be increased to 4⅞ per cent and the taxable wage base increased to $5,200 a year—for a total maximum employee/employer cost of $253.50 a year.

Hospital Rates

The average daily service charge for a hospital bed in the United States increased by one dollar last year, rising from $18.40 to $19.40 from the previous year, the American Hospital Association reported October 23.

A report on a recent survey, Daily Service Charges in Hospitals, 1962, showed a wide range in charges in various parts of the country and between metropolitan and non-metropolitan areas. The charge for a bed in a two-bed hospital room was $10.60 in rural Mississippi, for example, and $29 in the San Francisco-Oakland area.

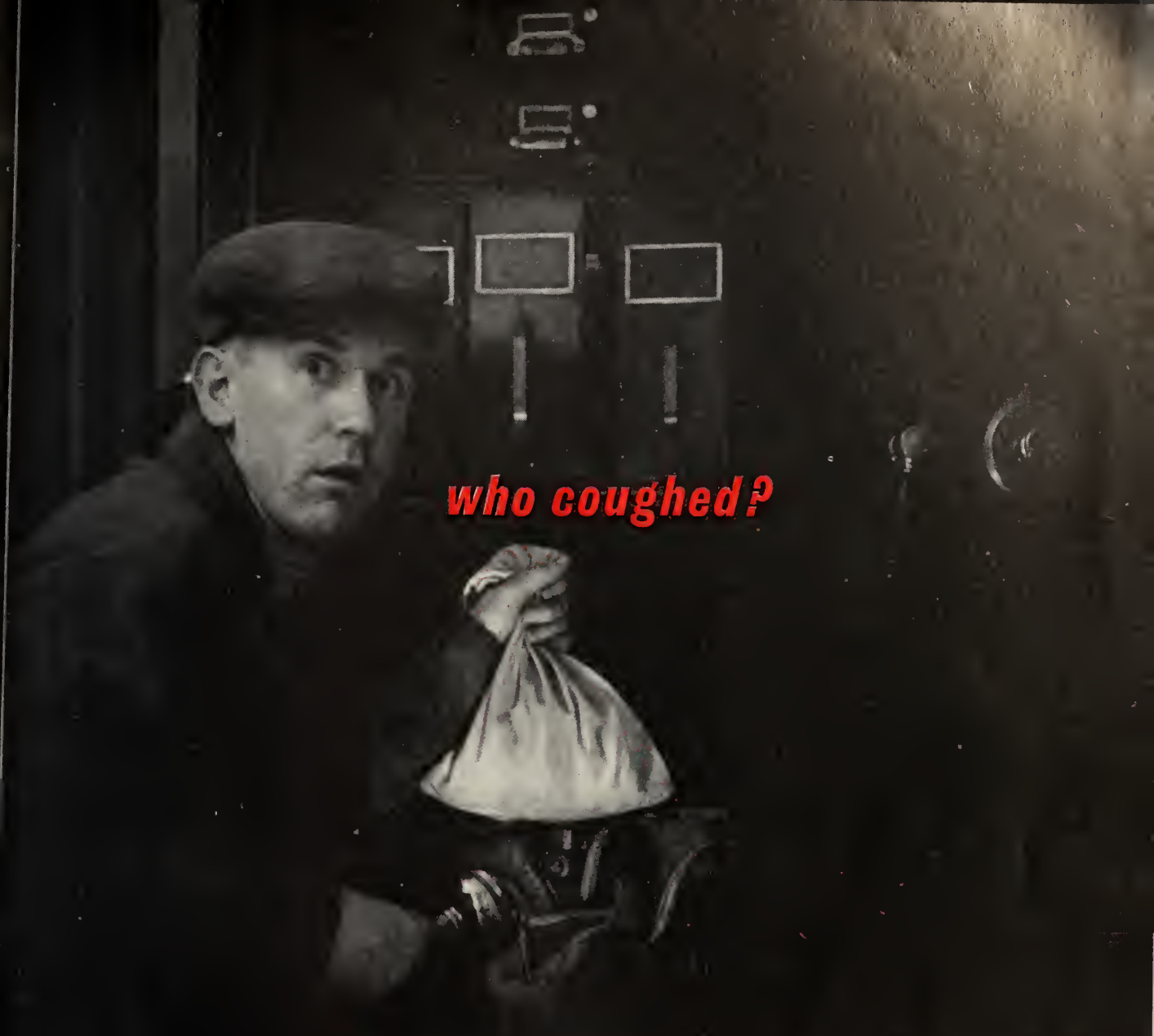
From Our Public Relations Library

The following books are recommended to interested doctors as stimulating and informative. Send a note to MSMS Library and the books will be sent by return mail for your perusal:

"Public Speaking for Business Men" by William G. Hoffman.

"How to Get the Most Out of Medical and Hospital Benefit Plans," prepared for the Foundation on Employee Health, Medical Care, and Welfare, Inc., by Ruth and Edward Brecher.

"Public Relations in the Local Community" by Louis B. Lundborg.



for fast and long-lasting cough control

HYCOMINE® SYRUP

Each teaspoonful (5 cc.) contains:

Hycodan®	
Hydrocodone bitartrate . . 5 mg.	6.5 mg.
(Warning: May be habit-forming)	
Homatropine methylbromide 1.5 mg.	
Pyrilamine maleate	12.5 mg.
Phenylephrine hydrochloride	10 mg.
Ammonium chloride	60 mg.
Sodium citrate	85 mg.

in a highly palatable, cherry-flavored vehicle (methylparaben 0.13% and propylparaben 0.02% as preservatives)

INDICATIONS: For both productive and nonproductive cough. For relief of symptoms in tracheitis, bronchitis, pneumonia, pharyngitis, bronchial asthma, pertussis, and allied conditions; cough associated with allergy; in general, whenever cough medication is indicated.

DOSAGE: Average adult dose—1 teaspoonful after meals and at bedtime with food. Children 6 to 12 years, ½ teaspoonful; 3 to 6 years, ¼ teaspoonful; 1 to 3 years, 10 drops; 6 months to 1 year, 5 drops; after meals and at bedtime. On oral Rx where state laws permit. U.S. Pat. 2,630,400.

CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine HCl and in patients with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients use should not exceed three days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur. May be habit-forming.

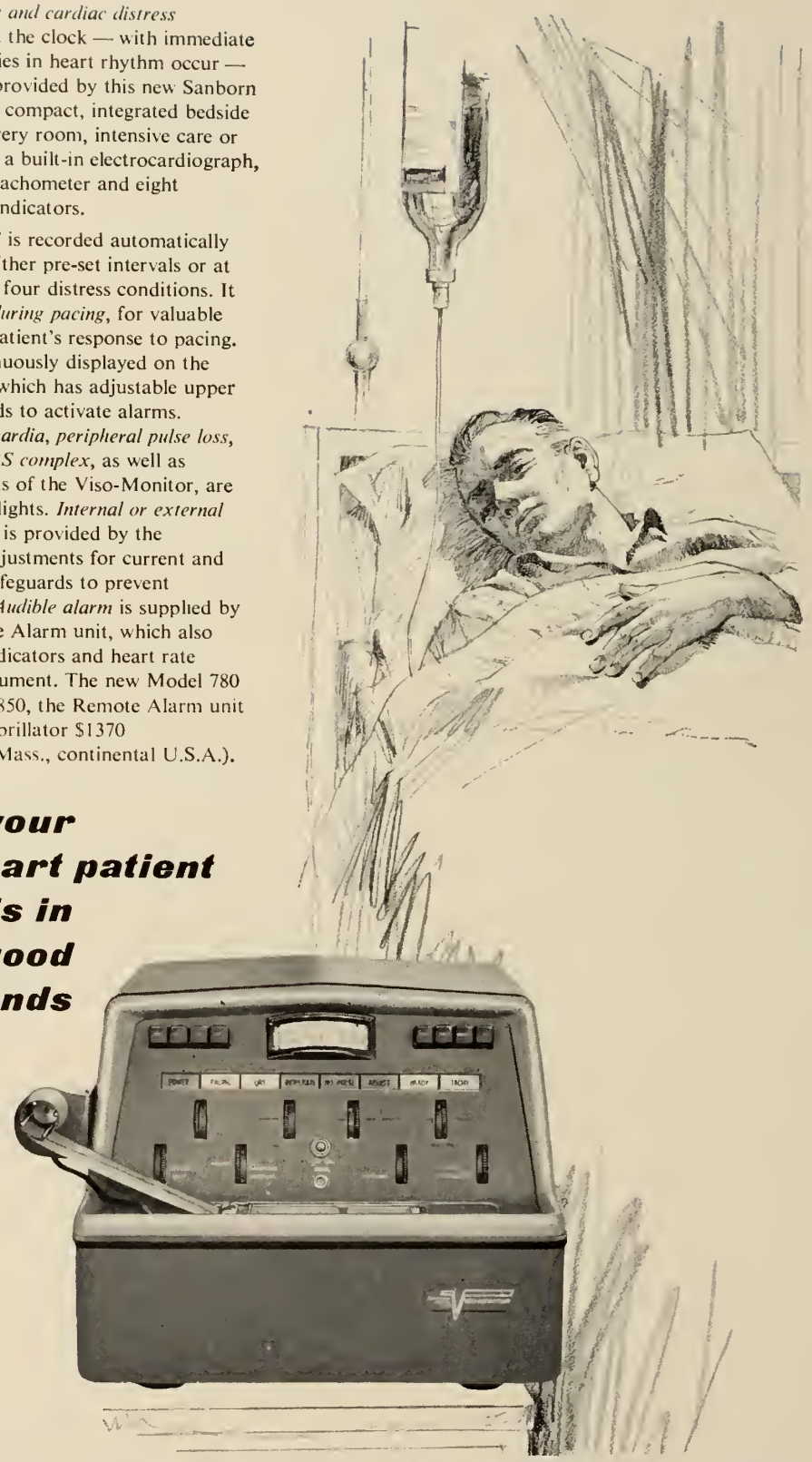
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Literature on request

ENDO LABORATORIES Richmond Hill 18, New York

Constant diagnostic and cardiac distress information around the clock — with immediate alarm if irregularities in heart rhythm occur — are automatically provided by this new Sanborn *Viso-Monitor*. This compact, integrated bedside system — for recovery room, intensive care or OR use — includes a built-in electrocardiograph, pacemaker, cardiotachometer and eight illuminated alarm indicators.

Your patient's ECG is recorded automatically for 10 seconds at either pre-set intervals or at the onset of any of four distress conditions. It can also be taken *during pacing*, for valuable knowledge of the patient's response to pacing. *Heart rate* is continuously displayed on the front panel meter, which has adjustable upper and lower thresholds to activate alarms. *Bradycardia, tachycardia, peripheral pulse loss, arrest* and each *QRS complex*, as well as operating conditions of the Viso-Monitor, are shown by warning lights. *Internal or external pacemaking current* is provided by the instrument, with adjustments for current and rate and positive safeguards to prevent accidental pacing. *Audible alarm* is supplied by an optional Remote Alarm unit, which also duplicates visual indicators and heart rate meter of main instrument. The new Model 780 Viso-Monitor is $1850, the Remote Alarm unit $250, and DC Defibrillator $1370 (F.O.B. Waltham, Mass., continental U.S.A.).



your heart patient is in good hands

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In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

® WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193

Special cough formula for children

Pediacof®

Each teaspoon (5 ml.) contains codeine phosphate 5 mg., Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) 2.5 mg., chlorpheniramine maleate 0.75 mg. and potassium iodide 75 mg.

soothing decongestant and expectorant



bright red, pleasant-tasting, raspberry-flavored syrup

Pediacof is different. It is designed especially for children, and each ingredient is in the right proportion. The potassium iodide in Pediacof is so well masked that it is virtually unnoticeable. Children like the sweet raspberry flavor of bright red Pediacof.

Dosage: Children from 6 months to 1 year, ¼ teaspoon; from 1 to 3 years, ½ to 1 teaspoon; from 3 to 6 years, 1 to 2 teaspoons; and from 6 to 12 years, 2 teaspoons. These doses are to be given every four to six hours as needed.

How supplied: Bottles of 16 fl. oz.

Available on prescription only.
Exempt Narcotic.

Side effects: The only significant untoward effects that have occurred are mild anorexia and an occasional tendency to constipation. However, discontinuance of Pediacof has seldom been required. Mild drowsiness occurs in some patients but, when cough is relieved, the quieting effect of Pediacof is considered beneficial in many instances.

Precautions and contraindications: Patients with tuberculosis or those who are known to be sensitive to iodides should not be given Pediacof.

Caution should be exercised if Pediacof is administered to patients with cardiac disorders, hypertension or hyperthyroidism.

Warning: May be habit forming.

Winthrop Laboratories
New York, N.Y.

Winthrop



BECAUSE NO TWO PATIENTS ARE ALIKE

Different Types, Different Dosage Comfort and carbohydrates—choice of a typical endomorph—may lead to constipation. Its etiology will be different for the tall, asthenic ectomorph, whose intestines are reported to be shorter and lighter in weight. Both may need the same peristaltic stimulant, but—will they react alike to the same dosage?

Unsurpassed Dosage Flexibility SENOKOT preparations solve the problem of individual laxative dosage adjustment. The dosage range is from ¼ to 4 teaspoonfuls or from 1 to 8 tablets—with every possible gradation in-between. Simple instructions enable the patient to find exactly the right dosage.

Gently Effective, Effectively Gentle With the right dosage, the action of SENOKOT Tablets/Granules is *predictably effective* for the given patient. Virtually colon-specific, this action is gentle, enjoying high patient acceptance.

SENOKOT

(standardized senna concentrate)

TABLETS/GRANULES

Recommended Starting Dosage: (preferably at bedtime) GRANULES (deliciously cocoa-flavored): Adults: 1 level teaspoonful daily (maximum—2 level teaspoonful twice daily). TABLETS: (small, easy-to-swallow): Adults: 2 tablets daily (maximum—4 tablets twice daily Supply: Senokot Tablets—Bottles of 30 and 100. Senokot Granules—4, 8 and 16 ounce (1 lb.) canisters.

THE INDIVIDUALIZED DOSAGE LAXATIVE

THE PURDUE FREDERICK COMPANY / YONKERS, NEW YORK



a split hair from perfect...

THESE STAINLESS-STEEL PINS TAKE ON THE APPEARANCE OF TINY FLAMING CANDLES BECAUSE OF THEIR HIGH POLISH.

This pin is 0.00032 of an inch larger than perfect. As a result, it is rejected. ■ Stainless-steel pins like this are used to mold Lilly capsules. From each tray of three hundred new pins, fifty are selected at random. The diameter, length, taper, contour, and finish are carefully measured. If the sensitive electronic measuring devices show an imperfection beyond the hairsplitting limits, the entire tray of three hundred is rejected. ■ Lilly quality control draws the line at ± 0.0003 of an inch for some dimensions and ± 0.0005 of an inch for others. A split hair can mean the difference between perfection and rejection . . . another of the many important controls that add immeasurably to the quality of the finished product.

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Lilly

400169

The Problem of Residual Or Recurrent Common Duct Stones

Post cholecystectomy biliary calculi create a clinical problem that may be avoided by the use of transduodenal section of the Sphincter of Oddi. Three cases are reported to illustrate this thesis.

Alfred M. Large, M.D.
Detroit, Michigan

THIS REPORT is concerned with the patient who has many stones within the bile ducts and who may require repeated explorations for the removal of these calculi, either because the stones have been overlooked at the first operation or because new ones have formed. Such individuals usually suffer from chronic cholangitis and some of them seem to develop a tendency to form mud, gravel and calculi within the ducts long after the gallbladder has been extirpated and long after all calculi appear to have been successfully removed. Actually, it is probably of little practical importance whether stones are left at operation or new ones form within the duct system. What is of more concern is the search for some procedure which will tend to eliminate the necessity for repeated operations in this small but unfortunate group of patients. Transduodenal section of the Sphincter of Oddi[4] appears to satisfy these requirements, as the following case reports will illustrate.

Case 1.—S. S., a 47-year-old white woman, was admitted to the Grace Hospital April 26, 1959, with the history of a recent attack of acute cholecystitis accompanied by pain, fever, and slight jaundice. The acute attack subsided on conservative management and an I.V. cholangiogram revealed stones both in the gallbladder and in the common bile duct. At operation on April 28, 1959, a chronically inflamed gallbladder containing numerous stones was found and three calculi were removed from the common bile duct. There was some question of slight stenosis of the Sphincter of Oddi; accordingly, transduodenal sphincterotomy was performed, although only a fold of mucosa was found over the area of the sphincter and no true stenosis existed. A T-tube was used to drain the common bile duct; operative cholangiogram showed what was thought to be a normal appearing duct system. The patient's postoperative course was satisfactory, but a T-tube cholangiogram taken one week after operation revealed what looked like a stone in the right hepatic duct. Another T-tube cholangiogram done three weeks later showed several stones in the common duct, apparently caught against the upper limb of the T-tube (Fig. 1). The lower end of the common duct appeared to be wide open, and after considerable deliberation the T-tube was removed. In spite of the known presence of the several large stones within the common bile duct, the patient remained symptomless; three months later an I.V. cholangiogram (Fig. 2) showed the duct to be normal; the stones had completely disappeared. It is apparent that the calculi must have all passed down through the open sphincteric apparatus without difficulty. This patient has remained well until the present time, except for the development of mild hyperthyroidism which has been well controlled with radioactive iodine.

Thus, as over three years have gone by since her sphincterotomy was performed, it is reasonable to assume not only that all stones within her ducts have passed into the intestine without trouble, but also that any chronic cholangitis present has cleared up and that no further stones have formed within the ducts.

Case 2.—E. W. P., a white man, aged 62, was first admitted to the Grace Hospital March 18, 1959, with obstructive jaundice for which, on the 28th of March, 1959, a cholecystectomy with exploration of the common bile duct

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was performed. There were many stones in the gallbladder and also numerous stones, gravel and sludge within the common bile duct. There was questionable narrowing of the Sphincter of Oddi, and a transduodenal sphincterotomy was performed. A T-tube was placed in the common bile duct and an operative cholangiogram performed; it appeared normal. The postoperative course was satisfactory, but T-tube cholangiogram taken ten days after operation revealed what appeared to be several retained stones in the common bile duct. A biliary flush regimen, such as is advocated by Best,[1] was used on two occasions, but without definite improvement in the cholangiograms. The patient was allowed to go home on the 28th of April, 1959, with the T-tube in place, but he returned to the hospital on the 6th of June, 1959, because of persisting X-ray evidence of calculi in the ducts. The T-tube in this instance was not removed, but re-exploration was performed on the 9th of June, 1959. To our surprise only gravel and sludge were found in the bile ducts; the duodenal end of the common duct was wide open; operative cholangiography was again normal. However, postoperative T-tube cholangiogram once more revealed what appeared to be numerous stones within the extrahepatic biliary system. The T-tube, which was kept in place, was irrigated from time to time with sterile saline solution, and on one occasion a small stone was washed out through the T-tube. Finally, in spite of the positive x-ray findings which continued to persist, the T-tube was removed on August 17, 1959. Following this, the patient has remained well, except for a recent urinary tract infection which has responded well to antibiotics. Intravenous cholangiogram has shown some dilatation of the common bile duct, but no evidence of stones.



Fig. 1. Case. 1. T-tube cholangiogram one month after operation. Dilated duct system with two stones caught against the upper limit of the T-tube.

This case thus also demonstrates the ability of sludge, gravel and stones to pass through the intraduodenal portion of the common bile duct without difficulty if the Sphincter of Oddi mechanism has been eliminated.

Case 3.—L. E., a colored woman, 33 years of age, was admitted to the Detroit Receiving Hospital on the 20th of February, 1961, for obstructive jaundice due to gall stones. Operation was performed on March 3, 1961. A chronically inflamed gallbladder containing numerous stones was found and the common bile duct was almost 2 cm. in diameter and packed full of calculi. The stones were removed as well as possible after the gallbladder had been taken out, and it was necessary to perform a transduodenal sphincterotomy in order to be sure that all the stones impacted at the lower end of the duct were removed. After this had been done, the common duct was closed around a T-tube and an operative cholangiogram, which appeared perfectly normal, was performed. Ten days later, however, T-tube cholangiogram revealed multiple calculi apparently hung up on the upper limb of the T-tube. In spite of these findings the T-tube was removed about one month after operation. Following this the patient had one slight bout of chills and fever, but except for this has remained well and has had no evidence of recurring pain or any other difficulty. It is reasonable to assume that all the calculi left within her duct system must have passed down into the intestine.

Discussion

Although gallstones almost always form in the gallbladder, it appears to be well established that certain individuals may continue to form stones and gravel in the common duct after the gallbladder has been removed. The presence of varying degrees of cholangitis

appears to be a constant accompaniment of this condition and probably is related in some way to the stone formation which occurs. Whenever stenosis or fibrosis of the Sphincter of Oddi exists in these patients, the circumstances the downward washing effect of continuous bile flow along the ducts not only prevents a significant degree of ascending infection from occurring, but also tends to eliminate any infection which already

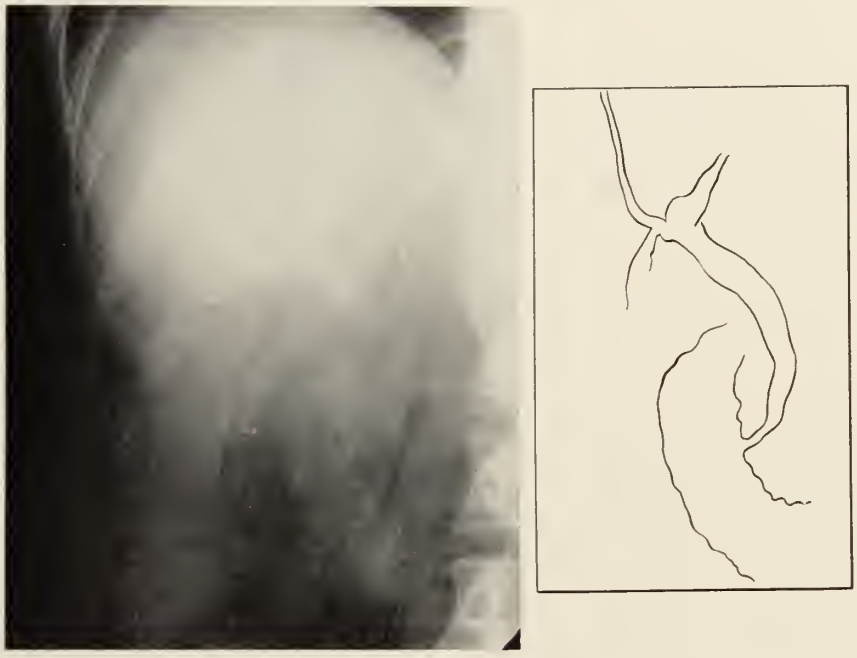


Fig. 2. Case 1. Intravenous cholangiogram three months after removal of the T-tube. Patient symptomless. The stones have disappeared.

partial obstruction of the lower end of the common duct doubtless acts to perpetuate the chronic cholangitis, and it is generally agreed that sphincterotomy is indicated. What is not so generally appreciated is the fact that the tone of the normal sphincteric mechanism may be sufficient to act as a partially obstructing outlet to the common duct in certain of these patients, enough to prevent any chronic infection in the biliary passages from being eradicated, and thus enough to stimulate the formation of concretions within the duct. Severance of the sphincter muscle in such patients thus appears to serve two useful purposes: (1) Any stones which the surgeon has overlooked at the time of operation may pass into the duodenum without difficulty; and (2) chronic infection within the bile ducts will tend to disappear, so that further stone formation is inhibited.

It has been possible in the past for us to show both experimentally and clinically that a wide opening between the biliary passages and the intestine is not harmful provided only that no blind pouch or sac, such as the gallbladder, be left in place to harbor and nurture any persisting infection.[3] Evidently under these exists. The present communication is concerned with this latter effect only to the extent that persisting cholangitis appears to be the one single factor constantly accompanying the recurrent formation of calculi in the bile ducts in persons who have already had the gallbladder removed. This line of reasoning thus points clearly to the usefulness of sphincterotomy in the management of patients who have chronic cholangitis with numerous calculi, gravel or sludge within the common duct even though no actual stenosis of the sphincter area may be demonstrated. The three patients reported in this paper have done very nicely even though the T-tube was removed in each instance when calculi were still present within the common duct.

The technique that we have used for sphincterotomy is actually that of sphincteroplasty and has been described by many others. Briefly, it consists of a 10 mm. incision through the duodenal papilla and through the entire sphincteric musculature, so that the Ampulla of Vater is laid wide open, and will admit the tip of the index finger with ease. The bile duct mucosa on each side of the incision is then sutured to the duodenal

mucosa with several interrupted fine catgut sutures, care being taken to avoid injury to the pancreatic duct. This latter maneuver we believe to be important both for the prevention of duodenal leakage and for the elimination of recurring sphincter tone, such as has been described by Eisman.[2]

An alternative method of management of these stone-forming individuals would be to construct an anastomosis between the supraduodenal portion of the common duct and the duodenum itself, either by cutting across the common duct, closing the distal end and suturing the proximal end as a wide open anastomosis end-to-side to the duodenum, or else by the more simple procedure of open side-to-side anastomosis between the common duct and the duodenum. The advantages of such procedures are said to include simplicity of performance and the assurance that the common duct remains a straight channel until it reaches the bowel, without any curvature or pouch formation where calculi might lodge and set up further trouble. However, the curved course of the retroduodenal portion of the common duct has not proved to be a problem in our patients who have had sphincterotomy performed; and sphincterotomy has seemed to us to be a much more anatomical and physiological procedure than direct choledochoduodenal anastomosis for this group of patients. It is our feeling that preservation of the lower portion of the common duct, particularly the intraduodenal portion, is wise; any bypassing operation may result in future trouble from overlooked stones or other pathological process which exists in the lower portion of the common duct, whereas these latter possibilities are obviously excluded by severance of the Sphincter of Oddi musculature.

Finally, it must be stressed that neither sphincterotomy nor any bypassing operation is suggested as a substitute for thorough exploration of the common duct at the time of the initial operation. The best treatment for stones in the common duct is to remove them. On this point there can be no argument. Only under the peculiar and unusual circumstances described in this report should sphincterotomy be considered as a measure useful in the healing of cholangitis and in the avoidance of further operations for residual or recurring stones.

Summary and Conclusions

Three cases are reported to illustrate the usefulness of transduodenal section of the Sphincter of Oddi in the management of patients with chronic cholangitis and multiple stones within the extrahepatic biliary passages. In these individuals, all of whom have had their gallbladders removed, it has been found that retained or recurring calculi within the common duct have passed without difficulty following sphincterotomy, and that all clinical evidence of recurring or persisting cholangitis has cleared up within a short period of time.

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Among the MCI Highlights:

Newspaper Columnist **Peter J. Steincrohn, M.D.,** will be one of the panelists for the MCI Evening Seminar, "When Our Parents Get Old," March 12. Doctor Steincrohn, of Coral Gables, Florida, writes daily in "The Detroit Free Press." Alexander H. Hirschfeld, M.D., Detroit, will be the other panelist, with Jack Rom, M.D., Detroit, the moderator.



Seven cases of unclassified mycobacterial infection are presented where the pathogenicity of the organism is definite along with eight additional cases where atypical acid-fast organisms have been isolated but pathogenicity is neither excluded nor proven.

Unclassified Mycobacterial Infection: Clinical Experience

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OUR EXPERIENCE in the laboratory with the unclassified mycobacteria has been described in the preceding paper. Unfortunately, no laboratory procedure, including animal pathogenicity, is absolutely indicative of human pathogenicity. The decision that a given isolate is a pathogen for a given patient requires careful evaluation of the clinical data and correlation with the laboratory findings, and even then an absolute decision cannot always be made.

We feel that we have identified seven definite cases of unclassified mycobacterial infection, three due to Group I, one to Group II and three to Group III organisms. In eight additional cases organisms have been isolated whose pathogenicity one can neither categorically claim nor exclude. These include one Group I, five Group II and two Group III organisms.

The clinical presentations follow.

Case 1.—A 49-year-old white man developed progressive abnormality in the right upper lobe. Old tuberculin (OT) and purified protein derivative (PPD) skin tests were negative on multiple occasions although the histoplasmin skin test was positive. The roentgenograms showed nodular infiltration, calcification and probable cavitation in the right upper lobe. Histoplasmosis or carcinoma was suspected. Bronchoscopy, sputum examination for malignant cells, complement fixation tests for fungus diseases and a right scalene lymph node biopsy were all nonrevealing, but acid-fast cultures were positive. Streptomycin, PAS, and isoniazid were given, with some roentgenographic improvement. An attempt at resection was abandoned for technical reasons. Two years later the old tuberculin was again negative but a skin test using a photochrome antigen was positive 1.5 cm. and a scotochrome OT positive 0.6 cm.

Three of four gastrics and six of eight sputum specimens were positive early in his course for photochromogenic organisms, although not all the colonies became deeply pigmented. Multiple subsequent cultures were negative. The organisms were streptomycin susceptible but isoniazid and PAS resistant. Many guinea pigs inoculated with his cultures were considered negative, although one showed a few microscopic lesions. He remains well in follow-up.

Case 2.—Infiltration with cavity in the right upper lobe appeared in 1956 in a 38-year-old Negro man. Isoniazid and PAS therapy resulted in slight resolution, with greater clearing after the addition of streptomycin. The old tuberculin was positive. After nine months of therapy an apical-posterior segmentectomy of the right upper lobe was performed. The lesions were markedly fibrotic histologically, and indistinguishable from tuberculosis.

One pre-admission culture and five of our sputum cultures were positive for photochromic organisms which were streptomycin susceptible, isoniazid resistant and variously susceptible or resistant to PAS. A guinea pig was reported positive at the State laboratory. In our own hospital a number of mice inoculated with the organism were uninfected, occasional modified positivity was obtained in the rat and guinea pig, and three hamsters definitely demonstrated disseminated disease.

Case 3.—This 55-year-old white man's chest x-ray was negative in December, 1958, when carcinoma of the pharynx was found and treated by radiation therapy. One year later he developed left chest pain. His roentgenogram now showed nodular disease in the left upper lobe with probable cavitation demonstrated by laminograms. The histoplasmin skin test was positive but only one of five old tuberculins was positive, and this with less reaction than he had to a photochrome skin test.

He was treated with isoniazid and PAS, with streptomycin

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added later, although clearing was apparent prior to institution of streptomycin. Three of six sputa were positive for photochromic organisms which were isoniazid resistant but streptomycin and PAS susceptible. They showed rapid catalase activity and were guinea pig and niacin negative.

These three cases represent clearcut examples of photochromic infection, with multiple isolations of the same organism and good response to therapy. All were Michigan residents, though all had traveled elsewhere. The negative old tuberculin skin tests in two were leads away from a diagnosis of tuberculosis. No roentgenographic or pathologic features could distinguish these patients from those with disease due to M. tuberculosis.

Case 4.—A 35-year-old white man developed weakness, weight loss, fatigue and splenomegaly. Anemia and white blood counts of over 100,000 per cu. mm. were found with differential and marrow examinations suggesting chronic myelogenous leukemia. He was treated with myleran and x-ray therapy to the spleen with some response. His symptoms recurred, however, and splenectomy was performed for an enlarging painful spleen. The surgeon commented that the lymph nodes within the small bowel mesentery were enlarged. Shortly thereafter he was admitted to our hospital with continued abdominal pain. The white count was 25,000 per cu. mm. with a shift to the left but without blast forms in the peripheral blood or an increase in blast forms in the bone marrow. Ascites and nodular abdominal masses were present. The chest roentgenogram revealed a left infrapulmonary pleural effusion. Old tuberculin and histoplasmin skin tests were negative. Radiation therapy to the abdomen and P-32 were given but his condition deteriorated and he expired. His preterminal x-ray also showed miliary pulmonary infiltration.

Two sputa collected prior to death were positive by culture for scotochromic pigmented mycobateria, which were considered non-pathogenic. The colonies were bright yellow, moist and smooth and did not increase in color when exposed to light. In liquid media no cording was found. The catalase was rapid, the niacin negative. They were susceptible to streptomycin but resistant to isoniazid and PAS. The organisms were not pathogenic for guinea pigs, but were minimally for mice.

The autopsy revealed large abdominal masses of caseous lymph nodes, which were necrotic microscopically, and diffuse nodular pulmonary infiltration due to small poorly formed epithelioid granulomata. The lymph nodes and lungs showed numerous large beaded curved intracellular mycobacteria by stain as did the other viscera. A definite diagnosis of leukemia could no longer be made. Cultures taken at autopsy from mesenteric lymph nodes, lung, ascitic fluid and heart blood were all positive for the same pigmented acid-fast organism.

We consider this an extremely rare example of disseminated disease due to a Group II organism.[1] Because of its failure to become more deeply pigmented after light exposure some authors would consider it a pigmented Battey or Group III-B bacillus,[2] but others feel organisms of this type represent a scotochromic sub-group. The debilitating effects of the leukemia and its therapy may have been partially responsible for this infection.

Case 5.—A 52-year-old white diabetic man, with peripheral arteriosclerosis, developed cough and hemoptysis in 1957. His roentgenogram showed a thick-walled cavity in the left upper lobe which became smaller with a thinner wall and then cleared over a period of months on penicillin therapy. He was admitted to our hospital one year later for diabetic gangrene, and an above-the-knee amputation was performed. His x-ray revealed a small thick-walled cavity in the left upper lobe, and a diagnosis of tuberculosis was made. The old tuberculin was positive. He was treated with isoniazid and PAS with little change, and an apical posterior segmentectomy was performed five months later revealing typical tuberculous histology. His sputum smear, however, remained positive postoperatively. Pre-and postoperative bronchoscopy did not disclose endobronchial disease. Residual nodularity in the anterior segment or a possible space at the line of resection were considered the source of persistent positivity.

Following a six-month retreatment course with streptomycin, oxytetracycline and pyrazinamide one year later he became negative and has remained so, although his peripheral vascular disease has led to bilateral amputation and is still a problem.

His skin tests were positive to OT and PPD, but negative to antigens prepared from Group III organisms. Precipitin bands to Battey and photochrome antigens appear in agar gel double diffusion tests.

Prior to surgery five of six sputum and four of six gastric cultures were positive, as was the operative specimen. Postoperatively, prior to retreatment, three sputa and six gastrics were positive, with subsequent specimens negative to date. The colonies were smooth, sharply circumscribed and buff in color. The organisms were short and beaded microscopically. Catalase activity was usually slow; the niacin was uniformly negative. Susceptibilities are available on eight separate isolates all of which are PAS resistant, six isoniazid resistant, and seven streptomycin susceptible. They were also penicillin resistant. We have records of eight separate guinea pig determinations, one of which included a pool of three organisms. Six were negative, including the pool; two guinea pigs were positive, one showing lesions only in the skin and omentum. The peculiar roentgen behavior in this case suggests that this might have been an abscess superinfected by these organisms, although a primary diagnosis of Battey bacillus infection is favored. The lack of effective preoperative chemotherapy is considered as important a cause of the postoperative positivity as is the residual disease.

Case 6.—A 79-year-old white man had had chronic cough for years. Cavitary tuberculosis in the left upper lobe was present on an x-ray in 1950 with minimal involvement on the right. He received some streptomycin from his local physician in 1956. He was admitted in 1959 largely for shortness

of breath. The two-hour postprandial sugar was elevated; the question of diabetes was never adequately settled. Routine skin tests including 250 tuberculin units of PPD were negative on multiple occasions early in his course; later a PPD prepared from Battey antigen was positive 6 mm. and the OT again negative. Still later, when on steroids, all tests were negative. His x-ray showed extensive bilateral cavitary disease involving both upper lobes and the superior segments of both lower lobes. No change was effected by therapy with multiple agents including isoniazid, PAS, pyrazinamide, dihydrostreptomycin, oxytetracycline and steroids. Other serious problems included hypoadrenalism and staphylococcal infection. He came to autopsy one year later. The lungs were pretty well destroyed by histologically typical caseating tuberculosis.

Thirteen of 16 sputum cultures and three stool specimens were positive during life. The growth of thin fine colonies which were smooth and creamy was usually scanty. A few colonies were pale yellow. The catalase activity was usually slow; the nacin always negative. Five guinea pigs were negative; one showed modified guinea pig positivity with lesions in the abdominal wall and omentum only. Ten isolates were ioniazid and PAS resistant, and only two were streptomycin susceptible.

Case 7.—A 71-year-old white diabetic man developed fatigue and weakness. Purpura, lymphadenopathy and splenomegaly were noted, and laboratory examination revealed neutropenia and thrombocytopenia. A clinical diagnosis of Hodgkin's disease was made, and he was treated with steroids with transient improvement. On admission to this hospital hepatosplenomegaly, leukopenia and anemia were found. Both hilar areas were full. OT and fungus skin tests were negative as were later special skin tests except for a small reaction to photochrome antigen. Precipitin bands to OT, Battey and possibly to photochrome were found in agar. The bone marrow aspirate was hypercellular, with epithelioid granulomata persistently present microscopically. A liver biopsy also revealed multiple granulomata. Cultures of the marrow were negative for acid-fast bacilli but unclassified non-pigmented mycobacteria were cultured from the liver and later from one gastric specimen. Treatment with multiple antituberculous drugs including isoniazid, PAS, dihydrostreptomycin, cycloserine, pyrazinamide and ethionamide was unsuccessful. Splenectomy improved the signs of hypersplenism but did not affect the clinical course, nor did preterminal steroid therapy. The spleen showed numerous granulomata with a positive culture for the same mycobacterium. A premortem blood culture was also positive; the terminal event was classified as generalized fungus infection with both Candida and cryptococcus.[1]

Scattered granulomata were found throughout all viscera at autopsy with some softening in peribronchial lymph nodes. Postmortem cultures of lung, peribronchial lymph nodes, liver and bone marrow were positive for the same organism isolated during life. The colonies were white to very pale yellow, smooth, moist and raised and did not change on light exposure. The cording was negative, the catalase variable and the niacin uniformly negative. The organisms were resistant to all the major chemotherapeutic agents. Two separate isolates showed typical guinea pig positivity.

These last three patients are definite examples of infection with Group III organisms which was quite difficult to treat and fatal in two. All had spent most of their adult life in Michigan. Pathologic and roentgenologic features which would allow differentiation from tuberculosis were not present.

The seven cases are summarized in Table I. Each had multiple isolations of the same organism, which included tissue in Cases 4 through 7. Significant underlying disease was present in at least two of the Group III infections (Cases 5 and 7) and in the scotochromic infection, contrasting with the otherwise healthy photochromic infection patients. The infection had undergone hematogenous dissemination in two.[1] Response to therapy was good in three and appeared related to drug susceptibility. Three patients succumbed.

The relationship between clinical infection and laboratory isolation is less distinct in an additional eight patients whom we have seen. These patients are summarized in Table II.

The patient in Case 8 had only one isolation, from a gastric, of a photochromic organism which was probably responsible for his bilateral upper lobe disease. We isolated scotochromic organisms twice from the patient in Case 9, who had had tuberculosis and thoracoplasty previously, but autopsy was not obtained when he expired of Hodgkin's disease, and we would require isolation of the organism from tissue to consider his case definite. The patient in Case 10 is a remarkable man with miliary pulmonary disease, pleural effusion, rheumatoid arthritis and Sjogren's syndrome. The only possible etiologic agent isolated from him was a scotochrome from pleural fluid. It may be responsible for his disease, but just as well may not be. Scotochromes were isolated twice from sputum of Case 11, and he had had indolent progressive bilateral disease for twenty years, untreated, with no other pathogen found. The scotochrome may be pathogenic, or the pulmonary changes not granulomatous, the organisms representing saprophytes or superinfectors. The rarity of documented scotochromic infection makes one dubious about the pathogenicity in Cases 9, 10 and 11, especially as the number of positive cultures is small.

The patient in Case 12 was a chronic bronchitic from whom we isolated Group III organisms on *three* separate occasions without evident related disease. Group III organisms are ordinarily associated with disease, unlike Group II's, but they have been reported in the sputum of apparent "normals."[4] The patient in Case 13 had a peculiar right upper lobe infiltrate

TABLE I. ESTABLISHED INFECTIONS

Case	Age	R	Other	Gp.	Organ	No. Pos. Source	Skin	Rx	Resp	Path	FU
1 RM	49	W	Alc.	I	Lung new RUL	9(6S,3G)	OT − OT −I+	ChRx	Good	−	Recov
2 AJ	38	N	−	I	Lung new RUL	6S	OT+	ChRx,res	Good	Fibr	Recov
3 WS	55	W	CA phar Alc.	I	Lung new LUL	3S	OT −(4/5) OT −I+	ChRx	Good	−	Recov
4 SJ	35	W	Leuk	II	Dissem.	6(2S,4PM)	None	None	None	Necr	Fatal
5 CL	52	W	Diab. ASO	III	Lung chr LUL	19(8S,10G, 1 Lung)	OT+ III−	ChRx,res	Fair	Typ	Recov
6 WG	79	W	Senil. ? Diab.	III	Lung, chr. bilat.	16(13S,3F)	OT − III+	ChRx	None	Typ	Fatal
7 PL	71	W	Diab.	III	Dissem.	8(1G,7Visc.)	OT − III−	ChRx	None	Typ	Fatal

TABLE II. POSSIBLE INFECTIONS

Case	Age	R	Other	Gp.	Organ	No. Pos. Source	Skin	Rx	Resp.	FU
8 JW	45	N	Alc. Pneu.	I	Lung, (new) bilat.	1G	OT+	ChRx	Good	Recov
9 SW	55	W	TB, TCP Hodgk	II	? Lung	2G	OT+ II−	−	−	Died, No PM
10 MK	52	W	R.A. Sjogr	II	Dissem.	1P1	OT+	ChRx	Equiv.	Impr
11 JP	64	W	CB	II	Lung, Chr. bilat.	2S	OT+ II−, +	ChRx	Equiv.	No change
12 DM	63	W	CB	III	? Lung	3S	OT+	−	−	Well
13 HH	73	W	Diab ASHD	III	Lung, bilat UL; ?LN, med.	1S	OT − III−	−	−	Died, No PM
14 SA	67	N	BPH	II	? GU	2U	OT+	−	−	None
15 LR	55	W	Pul TB	II	? Kidney	2U	OT+	ChRx	Equiv.	None

TABLE III. SKIN TESTING

PT.	GP.	PATH.	AFB?	OT	OTI	OTII	OTB	PPDB	AGAR
RE			TB	2+	1+	0	0	0	
AF			TB	2+	1+	0	0	0	
1	I	Yes	No	0	2+	1+	0	0	
3	I	Yes	No	1 1+; 4 0	2+	1+	0		
GM	II	No	No	1+		0			
9	II	Poss.	Yes	2+	1+	0	0		
10	II	Poss.	No	2+,1+	2+	0	0	0	
11	II	Poss.	No	2+	2+	0, 1+	0	0	
WB	II	No	No	2+	2+	3+	0	2+	
5	III	Yes	No	2+,0	1+	1+	0	0	Pos I, III
6	III	Yes	No	0	0	0	0	1+,0	
7	III	Yes	No	0	1+	0	0	0	Pos III, OT
13	III	Poss.	No	0	0	0	0	0	
EB	III	No	TB	1+	1+	0	0	0	

thought at first to represent tumor. It regressed, and one sputum grew out a niacin negative, guinea pig positive, Group III organism. He died of heart disease without a necropsy, and we have no definite diagnosis.

The final two patients each had two separate isolations of scotochromes from urine; in Case 14, the patient had nothing to suggest disease, but in Case 15 the patient had pulmonary tuberculosis from which M. tuberculosis had been recovered and also had definite disease of the left middle renal calyx. The possible pathogenicity of the organisms in these two cases is belittled by their isolation during the "spring epidemic" described in the previous paper.

In contrast to the group of established infections, the number of isolates in these cases is few; and underlying disorders which might diminish resistance and lead to infection with these relatively avirulent germs is less apparent.

We have had a superficial experience with skin testing and demonstration of precipitins in agar in these patients. Dr. John Chapman of Dallas performed double diffusion precipitin tests in agar gel in Case 5 (a Group III infection) and demonstrated bands to Group I and Group III antigen, and in Case 7 (also a Group III infection) with bands to Group III, OT and possibly Group I. The significance of these findings is unknown: the results can be interpreted as compatible with infection or sarcoidosis![5]

Skin testing materials we have used include a PPD-B (PPD-III) prepared by the Public Health Service, and OT material from Group I, II and III organisms prepared by Doctor Chapman. Our experience is presented in Table III. Two patients with Group I infection had their largest reaction to homologous material, but the photochrome antigen seemed quite potent in general. Only one patient with Group III infection reacted to PPD-III, and none to OT III. The use of these materials by others confirms the feeling that their usage and interpretation require further purification and clarification although, in general, homologous antigens tend to give strong reactions in low dosage as compared to heterologous antigens in patients with single given infections.[6]

Discussion

It is the purpose of this report to call attention to the occurrence of disease due to these organisms in Michigan, and the general subject will not be extensively reviewed. In 1959 Runyon[7] mentions only one case of unclassified infection, probably our photochromic patient (Case 2) in this state, but it is clear from this presentation that cases here are not rare.

The Group I photochromogenic organisms are a relatively homogeneous group, and the organism has been tentatively named *Mycobacterium Kansasii*. A geographic predilection for the Midwest seems present, with multiple cases in Minnesota, suburban Cook County, Illinois,[8] Kansas[9] and Texas. The absence of contact cases in families of patients with the disease is striking, even in highly endemic areas, although more epidemiological work is necessary. The disease affects older white males, and is clinically variable, like tuberculosis, from which it can be differentiated only by

bacteriologic methods. Chemotherapy is satisfactory when the organisms are susceptible.

Group II scotochromes are probably largely saprophytes, and disease produced by them is rare. They probably include multiple heterogeneous strains of organisms, which require further study and subclassification. Certain sub-groups may be more pathogenic than others, and are occasionally implicated in cervical lymph node or disseminated disease.[3] No geographic localization is evident.

Group III organisms do have their endemic area, the Southeastern United States, and in one study two-thirds of Navy recruits from this area had positive skin tests to PPD-B, compared to 10 per cent to PPD-S.[10] Nevertheless, disease is recognized less commonly there than is tuberculosis.[11] Again, it is unusual in Negroes and in household contacts of known cases. It may be more difficult to treat even when drug-susceptible, but this is not absolutely established. This group of organisms is relatively homogeneous, but appear related to avian bacilli and bacilli isolated from swine.[12]

The Group IV organisms are uncommon both in the laboratory and as pathogens. One species, M. fortuitum, has been delineated clearly. Suspected Group IV's must be differentiated from Nocardia species.

Summary

Unclassified mycobacterial infection in humans occurs, probably with some frequency, in Michigan. Correlation of clinical, roentgenologic and laboratory data is essential to establish the diagnosis in any given patient.

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MSMS President Johnson Urges Attendance at '64 MCI

Continuing education is one of the pillars of modern medical care. Research and studies to apply its findings are of little value if not available to as many patients as possible. To accomplish wide distribution of scientific developments requires group action in publishing, arranging courses or seminars and larger medical meetings. The Michigan State Medical Society has been outstanding in all of these endeavors. For years, the Michigan Clinical Institute held in March has brought to all physicians practical presentations available to those who take the opportunity of participating.

Again in Detroit on March 11, 12, and 13, the 1964 MCI will present panels, discussions and section meetings in a well-planned and thought-out manner. It will cover a wide range of medical subjects.

It will pay you well to go to this outstanding medical meeting of your state medical society. Plan now to go to Detroit in March.

Unclassified or atypical mycobacteria present a problem and a challenge to any tuberculosis laboratory. It is important to identify them and differentiate them from tubercle bacilli.

Unclassified Mycobacteria: Laboratory Experience

Constance S. Hertz, Shirley A. Pawlicki and Robert A. Green, M.D.
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AS INTEREST in the relationship of the unclassified (atypical; anonymous) Mycobacteria to disease in man has expanded, the laboratory worker has endeavored to improve procedures for the identification of these organisms and their differentiation from tubercle bacilli. It is our purpose in this paper to report our experience with them.

TABLE I. LABORATORY EXPERIENCE 1959-60 (18 MO.)

Source	No. Spec.	No. Pos. M. TBC	%	No. Pos. Uncl.	%
Sputum	2105	202	9.6	35	1.6
Gastric	746	31	4.1	10	1.3
Urine	271	12	4.4	1	0.3
Other	219	13	5.9	4	1.8
Total	3341	258	7.7	50	1.5

Table I demonstrates the frequency of the problem, even in our small hospital. Whereas 7.7 per cent of all specimens cultured for acid-fast organisms were positive for tubercle bacilli, 1.5 per cent were positive for unclassified Mycobacteria. Interestingly, 70 per cent of these unclassified organisms were isolated from sputum, and they occurred more frequently in sputum than in gastric aspirates: 1.6 as compared to 1.3 per cent.

Runyon[1] has introduced a useful tentative classification of these organisms which subdivides them into four groups:

Group I. Photochromogens become pigmented only after brief exposure to light;

Group II. Scotochromogens produce pigment in the dark or light;

Group III. Nonchromogens or so-called Battey-type organisms are non-pigmented;

Group IV. Rapid Growers grow rapidly even at room temperature.

The Runyon grouping is not a rigid or permanently established classification. Difficulties in assigning organisms to specific groups may occur, especially with certain slightly pigmented strains. It nevertheless provides a strong foundation from which to work.

Our laboratory routine is organized in the following manner. All cultures are incubated on solid media at 37°C in the dark and are examined at weekly intervals for growth. If rapid growth is noted at one week two tubes are subcultured, in the incubator and at room temperature, and observed daily.

When colonies of Mycobacteria characteristically appear after the third week their morphology is noted. The tube is then exposed to the light of a 25-watt bulb at a distance of 8 to 12 inches for one hour. The cultures are returned to the incubator and examined 24 hours later for the production of pigment. One unexposed tube is observed in the incubator for a prolonged period for late spontaneous pigment production.

The colonies are smeared and stained with an acid-fast stain. If the acid-fast nature of the bacilli is con-

From the Pulmonary Disease and Laboratory Services of the Veterans Administration Hospital, Ann Arbor. Presented in somewhat different form at the meeting of the Michigan Thoracic Society, Flint, October 25, 1962.

TABLE II.
CHART OF TESTS RUN ON ACID FAST BACILLI

Test	Ease of Performance	Value	Differentiates
Colony Morph.	++++	+	AFB variable
Micro. Morph.	++++	+	AFB variable
Pigment	++++	+++	Gp. I and II
Susceptibility	++	++++	M. Tbc
Cording	++++	++	M. Tbc
Growth rate	+++	+++	Gp. IV
Catalase	++++	++	Unclass. AFB; INH res.
Niacin	+++	++++	M. Tbc
Guinea Pig	+	+++	M. Tbc

firmed, one colony is placed in Dubos Serum Broth and incubated for 7 to 10 days. When growth is observed a smear is made, stained and examined for cording. From Dubos broth susceptibility determinations are performed on solid modified Lowenstein-Jensen medium containing appropriate amounts of antituberculous agents. Susceptibility is evaluated as soon as the control tube shows confluent growth. Three control tubes of the Lowenstein-Jensen media are prepared for each test, and subsequently used for catalase, niacin and animal inoculation procedures.

Colony morphology is simple to observe, but *M. tuberculosis* may not be completely typical until subsequent subculture. The colonies are rough, dry, buff, crumbly and difficult to disperse in water. Group I organisms are often smooth, but may resemble M. tuberculosis before exposure to light, after which they become yellow. The Group III organisms may also be similar but are ordinarily smooth and disperse easily in water. The Group IV organisms are more readily identified by their *growth rate* than their morphology. Group II organisms are characteristically smooth and orange.

M. tuberculosis requires a few weeks of incubation to grow, as do the unclassified organisms. Those of Group IV, however, cover the tube from minimal inocula in two to three days at room temperature.

Microscopic examination is essential to establish the acid-fast characteristics of the bacilli, but morphology of the individual cells is variable. Group I organisms tend to be long and beaded; Group III short and coccoid.

In broth culture the bacilli of M. tuberculosis characteristically group together in long coiled *cords* aptly referred to as serpentine cords because of their snake-like appearance. The photochromes occasionally form slight, loose cords; the others do not.

Drug susceptibility tests are helpful not only for the choice of chemotherapy, but also for identification, as M. tuberculosis tends to be susceptible to the major therapeutic agents whereas the unclassified Mycobacteria tend to be resistant.

The test for *catalase production* is useful as colonies of M. tuberculosis have a moderate rate of catalase activity which they lose, however, when they become isoniazid resistant or when they are heated. Many unclassified organisms, especially scotochromes, have excessive catalase activity which is not affected by isoniazid resistance or heating. The test is performed on cultures two to four weeks old. Equal parts of 30 per cent hydrogen peroxide and 10 per cent Tween 80 in distilled water are mixed just prior to use. A few drops of the mixture are dropped directly onto the colonies in the tube. Oxygen bubbles appear promptly, and the rate of production is considered negative, slow, moderate, or moderately or extremely rapid.

The *niacin test*,[2,3] one of the most valuable, reliably differentiates M. tuberculosis from all other acid-fast organisms. Niacin production is not affected by drug resistance. Unfortunately, the test must be performed on mature cultures, four weeks old or older. One to 2 ml. of sterile distilled water are added to a culture tube. The tube is slanted so that the water covers the colonies and is left in this position to extract the niacin: the longer the niacin is extracted the more clear cut the test will be. The water is poured into screw cap tubes and particulate matter allowed to settle. Five drops of the extract are placed in a small test tube. Two drops of 4 per cent aniline in 95 per cent alcohol and two drops of 10 per cent cyanogen bromide in distilled water are added. The tube is gently agitated and observed against a white background for a yellow color. A negative control of distilled water and reagents should be run. This reagent

TABLE III. CHARACTERISTICS OF ISOLATED UNCLASSIFIED MYCOBACTERIA

Group	No. Pts.	Path.	No. Cult.	Source				Niacin	Catalase	Susceptible To			GP
				Spu	Gas	Ur	Oth			INH	SM	PAS	
I	4	3 Def. 1 Poss.	19	15	4	—	—	1/1 Neg.	3/3 Rap.	0/8	8/8	4/8	2P, 2MP/11
II	34	1 Def. 5 Poss.	44	19	6	14	5	27/27 Neg.	26 Rap. 9 Mod. 7 Slow	9/41	34/41	27/41	3P, 2MP/34
III	16	3 Def. 2 Poss.	58	29	17	1	11	15/15 Neg.	4 Rap. 6 Mod. 16 Slow	4/33	18/33	8/33	4P, 3MP/29

TABLE IV. SUMMER 1959 EPIDEMIC
(7/29-8/19)

Pt.	Source	Diag.	AFB?	Cat.	INH	SM	PAS	GP
1. JT	1G	CA lung	No	Slow	R	S	S	Neg.
2. HR	1G	TB Eff.	No	Slow	S	S	S	Neg.
3. CB	1G	TB RUL	No	Slow	R	S	S	Neg.
4. SW	1G	TB LUL	M. TBC	Slow	R	S	S	Neg.
5. JC	1G	TB LUL	M. TBC	Slow	R	S	S	Neg.
6. AO	1U	TB RUL	M. TBC	Slow	R	S	S	Neg.

check also provides a color comparison for the test. The use of cyanogen bromide necessitates careful handling. During the niacin extraction and performance of the test the ultra-violet sterilizing light under the hood should be off as otherwise the yellow color may fade.

Lastly, *animal pathogenicity*, in the form of guinea pig inoculation, has long been a major means of differentiating between mycobacteria, and is performed for us at the state health laboratory.

Table II charts these procedures, compares their ease of performance with their relative value, and notes their specific function in differentiation of these organisms. We feel that susceptibility determinations and the niacin test are the most valuable. Morphology and catalase are simple to do albeit less important. The niacin test has superseded the guinea pig in differentiating M. tuberculosis from other organisms.

Table III details the characteristics of the organisms we have isolated. Nineteen cultures of Group I organisms have been recovered, largely from the sputum of four patients, in three of whom they were definitely pathogenic. The Group II isolates include 44 cultures from 34 patients, definitely pathogenic in one and possibly in five. These have been grown mostly from sputum and urine, with only six of 44 from gastric specimens. Our greatest numerical isolates are the 58 positive cultures of Group III organisms from 16 patients, isolated from various sources. In three patients disease due to these organisms was definite, and these three are responsible for the large total number. We have not identified any Group IV organisms. All isolates of all groups have been niacin negative. The catalase activity of the scotochromes tends to rapidity, but that of the Battey organisms is slow, as is the tubercle bacillus. Most of our organisms in all groups tend to be isoniazid and PAS resistant, but a surprising number were streptomycin susceptible: all the photochromes, most of the scotochromes and about half the Battey bacilli. Isoniazid resistant organisms continue to be catalase active, unlike the tubercle bacillus. In the last column note that we have seen typical guinea pig positivity with organisms from all groups; others have shown limited pathogenicity and are listed as MP or "modified positive."

In none of the patients from whom Group I photochromes were isolated was the tubercle bacillus isolated at any time. Of the 25 patients from whom scotochromes were isolated from sputum or gastric specimens, 15 had never had the tubercle bacillus isolated; 10 had. In these 10, the scotochrome appeared during drug therapy in two, soon after drug therapy was stopped in two, and long after in six. This is of interest as some authors, dealing with sanatorium rather than general hospital populations,[4] have suggested that these organisms appear as a good prognostic sign towards the end of chemotherapy.

An interesting feature in our laboratory has been two "epidemics" of recovery of unclassified organisms. In three weeks during the summer of 1959 (Table IV) six cultures of smooth creamy organisms were isolated from gastrics and one urine from six patients all of whom were from the tuberculosis ward of the hospital, and from most of whom typical M. tuberculosis had

TABLE V. SPRING 1961 EPIDEMIC
(4/14-6/12)

Pt.	Source	Diag.	AFB?	Nia.	Cat.	INH	SM	PAS	GP
1. HS	1U	BPH	No		Rap.	R	S	S	Neg.
2. SA	2U	BPH	No	Neg.	Rap.	R	S	S	Neg.
3. FM	1U	Hemat.	No	Neg.	Slow	R	S	S	Pos; Neg.
4. JG	1U	Sponge Kid.	No	Neg.	Mod.	R	S	S	Neg.
5. CL	1U	Pulm. Tbc	M. Tbc	Neg.	Mod.	R	S	S	Neg.
6. SG	1U	CA blad.	No	Neg.	Mod.	S	S	S	Neg.
7. JW	1U	Strict.	No	Neg.	Rap.	R	S	R	Neg.
8. JN	1U	Hemat.	No	Neg.	Mod.	R	S	S	Neg.
9. LR	2U	Pul ?GU Tb	M. Tbc	Neg.	Slow	R	S	S	Neg; Pos, Neg.
10. JH	1U	Epidid.	No	Neg.	Mod.	R	S	R	Neg.
11. LH	1G	Pneu.	No	Neg.	Slow	R	S	R	Mod. Pos.

TABLE VI. NIACIN NEG. GP POS. ORGANISMS

Case	Group	No. Pos. Source	Pathogenic	Nia.	GP	Susc.
5. CL	III	19(8S, 10G, 1L)	Yes	Neg.	1 Typ. Pos. 1 Mod. Pos. 6 Neg.	PAS R INH R 6/8
6. WG	III	16(13S, 3st)	Yes	Neg.	1 Mod. Pos. 5 Neg.	All 3 R
7. PL	III	8(1G, 7 Visc.)	Yes	Neg.	2/2 Typ. Pos.	All 3 R
13. HH	III	1S	Poss.	Neg.	Typ. Pos., Repeat Pos.	INH, PAS R
MD	III	1G	No; Potts	Neg.	Mod. Pos.	All 3 R
15. LR*	II	2U	Poss; TB L	Neg.	1 Neg. 1 Typ. Pos., Repeat Neg.	INH R
FM*	II	1U	No	Neg.	Typ. Pos. Repeat Neg.	INH R
WB	II	1U	No	Neg.	Mod. Pos.	INH R
LH*	II	1G	No; pneu.	Neg.	Typ. Pos., Repeat Neg.	INH, PAS R

*spring epidemic

also been isolated. The characteristics of these organisms were similar. The point source of these presumed saprophytic Group III contaminants was never identified.

During two months of the spring of 1961 (Table V) 13 cultures, mostly of urine, were positive for orange scotochromic organisms. In our entire experience we have had 15 unclassified isolates from urine, and 12 of these were during this period. These patients were scattered throughout the hospital, and the source of contamination presumably in the laboratory, but again the point source was not identified, although similar organisms have been isolated from tap water. The characteristics of these scotochromic bacilli were similar.

A few words regarding the comparison of the niacin test and guinea pig pathogenicity are necessary. It is well known that animal and human pathogenicity do not correlate completely. Isoniazid resistant tubercle bacilli are ordinarily not pathogenic for the guinea pig, and pathogenic unclassified organisms are often guinea pig negative. Although the two procedures are extremely helpful in concert the niacin is probably the more reliable of the two. We have had state laboratory reports of positive animal inoculations with niacin negative organisms from nine patients (Table VI). In three of the nine, the organism was pathogenic and in two others may have been; in the other four the organism was clearly not pathogenic yet the guinea pig was positive. Interestingly, three of these were organisms recovered during the spring 1961 epidemic. Most of the organisms were drug resistant, thus supporting their non-tuberculous nature, and all were niacin negative. Although some, as Cases 5 and 6, showed modified or infrequent guinea pig positivity, in others, such as Cases 7 and 13, the positivity was typical and replicable.

Summary

The unclassified mycobacteria present a problem to any tuberculosis laboratory. The characteristics of the organisms we have isolated, and the mechanics and value of the procedures we use to identify them, are described. Susceptibility determinations and the test for niacin production are considered the most valuable at the present time.

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Attention, Doctor: Please read Program Information about the 1964 Michigan Clinical Institute, March 11-12-13, on Pages 83, 114, 120, 129, 137.

Arterio-Venous Fistulae and Reticulo-Endothelial Activity

Sub-acute bacterial endocarditis is seen in patients with an abnormality of the endothelium. Experimental evidence is presented to suggest the importance of a related depression in reticulo-endothelial system activity in allowing infection to occur.

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LILLEHEI and his collaborators[1,2] showed in 1950 that dogs in which large arterio-venous fistulae had been constructed went on to develop bacterial endocarditis. They called attention to previous case reports of a similar association in man. Despite subsequent studies,[3] the exact mechanism involved remained obscure. Their suggestion was that an increased susceptibility of the endocardium to infection occurred as a result of the markedly increased work load of the heart. Recently Lee and Fisher[4] have reported on a similar experimental model in the rat. They observed a decreased clearance of injected bacteria from the blood during the second week following creation of an aorto-caval anastomosis. The purpose of the present study was to determine whether the development of endocarditis in the dog was related not only to local changes in the heart valves but also to a generalized depression in reticulo-endothelial activity brought about by the marked hemodynamic derangement associated with arterio-venous fistulae.

Materials and Methods

Reticulo-endothelial activity was measured by the method of Biozzi and others[5] using the decay of an intravenously administered suspension of carbon particles. India ink* was centrifuged at 2500 r.p.m. for 60 minutes and the supernatant collected. Electron microscopy verified a uniform particle size of 250 A° or less. A suspension was made in 3 per cent gelatin to contain 50 mg/ml. pH was corrected to 7.4 with N/10 ammonium hydroxide.

Adult mongrel dogs were anesthetized with Thiopental Sodium 2.5 per cent and then heparinized intravenously (2.0 mg/kg). An indwelling polyethylene catheter was placed in the jugular vein to facilitate collection of blood samples. After a control specimen was obtained, 40 mg/kg of the carbon suspension, previously warmed to 37° was injected over a 30 second interval. Blood samples were then collected at frequent intervals. Light transmittance was determined using a Klett-Summerson photoelectric colorimeter and blood carbon concentrations later were calculated by reference to previously prepared standard curves. Granulopectic indices comparing the slope of the blood carbon decay for each dog were determined from the following formula:

$$K = \frac{\text{Log } C_1 - \text{Log } C_2}{t_2 - t_1}$$

where K is the granulopectic index, C_1 and C_2 are carbon concentrations at times t_1 and t_2. These time intervals were arbitrarily fixed at 5 and 20 minutes following injection—a period of maximal decline.

One group of dogs had arterio-venous fistulae constructed between the abdominal aorta and the infrarenal portion of the vena cava immediately following the initial determination of their granulopectic indices. The size of the fistula varied between 6 and 15 mm in proportion to the animal's weight. Surgery was per-

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*Pelikan, C11/1431A, Gunther Wagner, Hanover, Germany.

formed under sterile conditions using an everting continuous suture of 6-0 silk. A sham operation was performed in a second group of dogs, no fistula being constructed. All animals were maintained postoperatively on standard kennel rations and received procaine

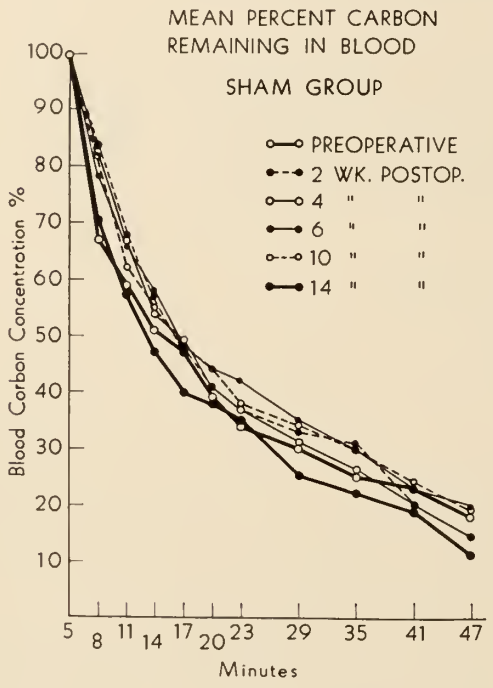


Fig. 1. Mean decay curves illustrating no evidence of a saturation effect or significant change in carbon clearance in the control group of seven dogs.

penicillin 300,000 units intramuscularly daily for a week. Subsequent granulopectic indices were determined on each animal in both the sham operated and the experimental groups at the second, fourth, sixth, tenth, and fourteenth weeks postoperatively. The dogs were examined frequently for evidence of heart failure, development of cardiac murmurs, changes in the character of the abdominal bruit, and fever. Blood cultures were obtained preoperatively and at the sixth, tenth, and fourteenth weeks following surgery.

Results

1. *Control Group.*—Five of the original seven sham operated dogs survived, one dying from distemper at the fourteenth day postoperatively, and the other as a result of an anesthetic overdose given during determination of the granulopectic index at six weeks. The five living dogs remained in excellent physical condition during the study.

Figure 1 illustrates the mean percentage of carbon present in the blood from the fifth to forty-seventh minute after injection as measured in the sham dogs preoperatively and postoperatively. No consistent change in clearance rate was observed.

2. *Experimental Group.*—Six of the 11 dogs in whom arterio-venous fistulae were constructed were living at the fourteenth week. Four early deaths occurred, from pulmonary edema, in animals having A-V fistulae greater than 1.5 cm. The fifth death occurred in a dog with chronic right heart failure, six weeks after operation. Of the six dogs studied, two have been excluded. These had fistulae of 6 mm and 8 mm, respectively, and carbon uptake closely approached that of the sham dogs. The remaining four dogs had fistulae between 1.0 and 1.4 cm. Two of these developed ascites at three and five weeks, respectively. Blood cultures were inconsistent. A varied bacteremia

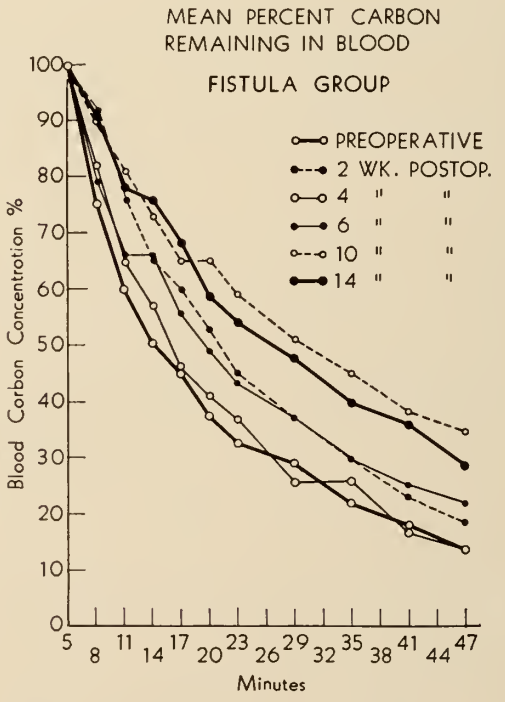


Fig. 2. Mean decay curves of four fistulae dogs demonstrating the delay in carbon clearance at the second and sixth through fourteenth week periods.

(Escherichia coli in three, Pseudomonas aeruginosa in one, and Staphylococcus aureus in one) was reported at six to 10 weeks but no persistent organism appeared in any of the dogs. All four showed a diminished exercise tolerance but no fever, cardiac murmur, or changes in the abdominal bruit occurred.

Figure 2 illustrates the mean per cent of blood carbon in these four fistulae dogs. Significant delay in carbon

clearance is noted between the preoperative and second week determination whereas considerable recovery had occurred by four weeks. Thereafter a progressive and continuing delay in carbon uptake occurs.

The granulopectic indices in the two groups are compared in Figure 3. While only minimal changes in the rate of clearance of carbon particles occur in the sham series, the fistulae group demonstrate a marked depression in activity at the second and sixth through 14-week periods.

Discussion

There is considerable evidence that the clearance rate of a carbon suspension from the blood reflects reticulo-endothelial activity.[7-11] The granulopectic indices obtained preoperatively in the two groups of dogs were similar to each other and the values agree with those reported by other investigators. It is of interest that in the control series despite repeated carbon injections leading to a total dosage of 240 mg carbon/Kg body weight over a five-month period, there was no suggestion of a saturation effect.

The size of the fistula is a critical factor in these experiments. Fistulae greater than 14 mm in diameter produced death from pulmonary edema immediately following surgery while fistulae of 8 mm or less appeared to have no depressant effect on reticulo-endothelial activity.

The results obtained in dogs with a fistula from 9 to 14 mm in diameter indicate a transient early and a more persistent later depression in reticulo-endothelial system activity. The initial fall in activity is associated with the sudden development of a large "leak" in the circulation with possible compromise in blood flow to the liver and spleen, the predominate reticulo-endothelial organs. Some adaptation apparently occurs by four weeks as the granulopectic indices return to normal. The later decline is associated with signs of cardiac failure appearing at the sixth week and may be attributed to the resulting circulatory changes.

These findings all occurred in the absence of either bacteremia or signs of endocarditis. They suggest, therefore, that the development of the latter complication may be related to other factors in addition to a local valvular stress. This hypothesis helps to explain the observations of Lee and Fisher who noticed a depressed clearance of injected bacteria seven to 14 days postoperatively using a similar preparation in the rat. In addition, Lillehei reported originally that spontaneous development of endocarditis required a lag period of at least six weeks.

Summary

Blood clearance of a carbon suspension in gelatin appears to be an easy and reliable method for determining reticulo-endothelial activity in the dog without producing a saturation effect. An early temporary and a later more profound depression in function is demonstrated in dogs with moderate size aorto-caval fistulae. The results suggest that endocarditis occurring in animals with large A-V fistulae is related not only to a local change in valvular endocardium as a result of the increased work load but also a generalized depression in reticulo-endothelial system activity.

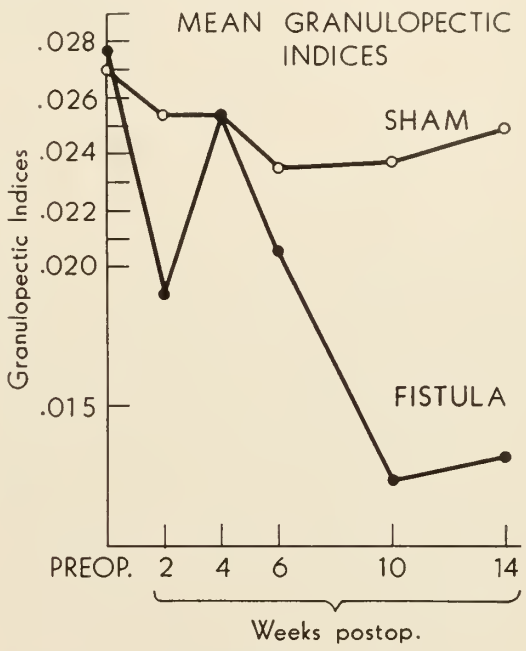


Fig. 3. Mean phagocytic indices of the control and experimental groups illustrating the transient early and later persistent depression of reticulo-endothelial system function.

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(Additional References on Page 154)

There are ways for every physician to offer guidance to the visually handicapped. A number of facilities and sources of aid are reported.

Aid to the Blind

Dean Bentley, M.D.
Cadillac, Michigan

IN THE practice of ophthalmology we are sometimes forced to face our failures and attempt to treat the blind in other ways than just eye care. People who are faced with permanent blindness are often desperately depressed and are frequently not aware of the various possibilities for re-establishing a cause for living. As physicians we should be capable and willing to take the time to guide these people even though they need no active medical attention. This paper is an attempt to get under one heading some of the various civilian and government projects available as a reference in aiding and counseling the blind.

We are sometimes confronted with a patient who is not totally blind but who is seriously handicapped visually. The Shiffman Clinic Out-patient Program of the Sinai Hospital in Detroit maintains a low vision clinic where a variety of optical devices may be offered to permit utilization of residual vision. This includes special lenses, microscopic lenses, telescopic lenses, doublet magnifiers, contact lenses and any other such aids as might be beneficial. There is apparently a charge for this service; however, if your patient is unable to pay, then arrangements can be made through the Office of Vocational Rehabilitation or the Crippled Children's Commission.

The excellent work that the Lions Club does in treating and helping the blind is well known. Information concerning their projects can be obtained from any local Lions Club. They have a service providing seeing-eye dogs. They also have a home for the blind in Grand Rapids which I am told is more for older people. They are also active in maintaining eye banks.

The American Foundation for the Blind, Inc., 15 West Sixteenth Street, New York 11, New York, has a special service which offers nonprofit mail order service to provide commercially adapted, or special devices which in one way or another solve or reduce the problems resulting from blindness. These services provide a variety of things such as alarm clocks, chess sets and other games, geographical aids, kitchen aids, compasses, slide rules and other mathematical aids, special typewriters, musical aids, travel aids and a great many other things that can be purchased from the above address. This foundation publishes a catalog which can be obtained from the above address. It has also distributed many thousands of gift radios to the sightless who are unable to afford this luxury.

The American Foundation for the Blind also has a booklet entitled Travel Concessions for Blind Persons. This booklet explains how a blind person can acquire a travel concession. Most railroad companies grant a blind person a right to travel with a seeing attendant for the cost of one fare. This is also true of most bus lines. Application forms are furnished by the American Foundation for the Blind upon request. These forms are then returned to the American Foundation for the Blind and entitles the applicant to an identification card and a book of coupons which is renewable each five years. There are also some concessions on steamship and foreign travel.

The Library of Congress at Washington 25, D. C., has a reference department division for the blind. This federal agency supplies talking book machines and talking book records on loan without charge, to persons whose central visual acuity is 20/200 or less in the better eye. This is no more than a phonograph which plays thirty-three and a third r.p.m. records. They will also supply a catalog listing the records available. There are thousands and thousands of records available on practically every subject imaginable from modern novels to educational subjects. I have found these to be a real help and source of pleasure. Information can be obtained by writing the Library of Congress at Washington 25, D. C. Applications for the loan of a talking book machine accompanied by a statement from a family doctor or an ophthalmologist

certifying as to the eye condition of the applicant, can be submitted to the State Library for the Blind, 924 Houghton Street, Saginaw, Michigan. Most local city libraries can also furnish information concerning these talking book machines.

The Kansas Rehabilitation Center for the Blind is a division of the services for the blind which is one of the departments of Social Welfare. This is not restricted to Kansas residents only and students from all over the Midwest have attended as well as veterans who have lost their vision. The students are taught how to travel alone, how to read and write Braille, telephone dialing, lessons in Morse code, training in poise, grooming, and table etiquette as well as being given counselling for any personal problems. Further information concerning this service can be obtained from the Director of The Division of Services for the Blind, State Department of Social Welfare, 801 Harrison Street, Topeka, Kansas.

Our state of Michigan has an employment institution for the blind located in Saginaw, Michigan. This institution provides prevocational training such as travel and Braille, vocational training such as weaving, broom making and other supplemental services. It also offers recreational opportunities with bowling alleys and gymnastic equipment. Further information can be obtained from your local county Bureau of Social Aid or by writing The State Department of Social Welfare, Division of Services for the Blind, 4th Floor, Lewis Cass Building, Lansing, Michigan, or the Michigan Employment Institution for the Blind, 924 Houghton Street, Saginaw, Michigan.

The Federal Social Security Act and the Michigan Social Welfare Act authorize monetary assistance known as Aid to the Blind which is available for certain persons with impaired vision. There are quite a few qualifications before this aid can be available, but information can be obtained through the county Bureau of Social Aid.

The Michigan State Department of Social Welfare, Division of Services for the Blind at 230 North Grand Avenue, Lansing 4, Michigan, can supply a list of known employment opportunities for the legally blind. The State Department of Social Welfare also has a vocational rehabilitation program and further information can be obtained by writing the Division of Services for the Blind, Lewis Cass Building, Lansing 13, Michigan. This can also be obtained from your county Bureau of Social Aid. This division furnishes such things as counselling, physical examination, vocational diagnosis, medical services, personal adjustment services, job placement, tools, equipment, stock and licenses, small business enterprise programs and job adjustments. Any person is eligible for this vocational rehabilitation providing he has lost enough sight so that his disability interferes with his employment. He must have a reasonable chance of engaging in remunerative work, he must want to work, and he must be at or near normal working age. This vocational rehabilitation agency has a pamphlet which can be obtained from the above address or the Office of Vocational Rehabilitation, U. S. Department of Health, Education and Welfare, Washington 25, D. C.

The above list is not complete, however it will offer a starting point for any physician seeking help for his blinded patient.



Among MCI Highlights:

The speaker for the Annual Michigan Foundation for Medical and Health Education Lecture will be **Leroy G. Augenstein, Ph.D.**, East Lansing, at 4 p.m., March 12. Formerly with the U.S. Atomic Energy Commission, Doctor Augenstein is chairman of the Department of Biophysics at Michigan State University. His topic will be "Moral Decisions Facing Medicine Arising from Scientific Advances."

Routine Chest X-Rays In Prenatal Care

Results are presented from prenatal chest x-rays obtained in 2,262 patients and the radiologic hazard is evaluated. The positive case for the use of such chest x-rays is presented.

L. A. Miller, M.D. and John N. Wolfe, M.D.
Detroit, Michigan

PRENATAL care represents the first application of preventive medicine to the field of obstetrics. It has been useful in detecting the inadequate or contracted pelvis, in recognizing the early signs of toxemia, and in discovering other impending complications. Obviously, in pregnant women early diagnosis of an ensuing abnormality or infection which may deter the outcome of a normal delivery of a healthy infant is of utmost importance. For this reason we have undertaken a study to determine the value of a routine chest x-ray of all pregnant patients as part of their prenatal care.

During recent years, the value of the regular examinations of healthy individuals has been queried and, at the same time, voices have been raised in warning against risks attendant on repeated radiation exposure. We have therefore endeavored to evaluate the radiation hazards involved as compared to the knowledge and benefit obtained in chest radiography.

Method

During the past five years from July 1, 1955 to July 1, 1960, routine minifilms were taken on 2,262 prenatal patients of which 468 were Caucasian and 1,794 were Negro. All the patients were between 14 and 44 years of age and were relatively asymptomatic. The x-rays were taken at any time during gestation from the third to the ninth month. The reports of the minifilms were classified as (1) negative chest, (2) minor pathology, (3) major pathology, or (4) further studies advised. Table I lists and categorizes our findings. We are concerned with those listed as "major pathology" and the results of the findings upon the patient when further studies were advised. Were it not for the use of the routine chest x-rays on these patients, three pregnant women might have gone to term without a diagnosis of tuberculosis. The danger of infecting the expected child and those about her in the hospital can not be minimized, as well as the harm done to herself. Buhl, et al[1] completed a study of routine x-rays in 5,737 pregnant patients in Denmark in 1959 in which they found six previously unrecognized cases of tuberculosis. They have therefore advocated the use of routine chest x-rays.

TABLE I

Minifilm Report	Negative	Minor Pathology	Major Pathology	Further Studies Indicated
	2,087	147	21	3
Cardiac Enlargement		138		
Thoracoplasty on Left		1		
Lobar Pneumonia		2		
Soft Tissue Mass on Rt. Arm		1		
Prominent Kyphosis		3		
Enlarged Hilar Nodes Suggestive of Sarcoidosis		2		
Healed Tuberculosis			18	
Sarcoidosis			2	
Probable Tuberculous Destruction 5th Rib			1	
Tuberculosis				2
Miliary Tuberculosis				1

The primary purpose of doing routine chest x-rays in prenatal patients is to detect active disease so that the individual with tuberculosis may receive prompt and adequate treatment and the source of infection to her child and to the community may be removed. While no one can or will deny the pitfalls and shortcomings of chest surveys by minifilms, it appears that pulmonary abnormalities occur to a significant degree in many asymptomatic patients. Whether the benefits of a chest x-ray outweigh any possible complication,

From the Woman's Hospital, Detroit, Michigan.

disease or genetic change arising in the offspring is difficult to ascertain.

Radiation Hazard

For several years now the possible relationship of irradiation showered upon a mother during gestation and the incidence and probability of leukemia in her offspring has gained publicity. In 1956, Stewart et al[2] published a preliminary report which showed that, in a group of children dying from leukemia and other malignant diseases, diagnostic irradiation of the mother's abdomen during pregnancy had been significantly more frequent than in a control group. Authors who have been inclined to accept the leukemogenic action of diagnostic irradiation in pregnancy have concluded that a dose of 25 mr. doubles the leukemia rate.

There have been many men who have criticized this conclusion, including Rabinowitch[2] (1956-57); Reid (1957); Jackson (1958); and Parlee (1958); their most imposing argument being that the irradiation to the fetus is too small and definitely lower in amount than that given to numerous diseases.

Tage Kemp (1958)[3] claimed that the genetic risk is not substantially increased for the offspring of an individual who, from conception to the age of 30 years, has received a background irradiation to the gonads amounting to a maximum of 50 r.

Several studies have been undertaken to determine the gonadal dose. Lars-Eric Larsson in Sweden (1958),[5] Koren and Maudal in Norway (1957)[4] and Stanford and Vance in England (1955)[6] have determined the gonadal dose. In mass miniature radiography, the dose was found to be 0.15 mr. in each examination.

Discussion

In the study of Buhl, Ingerslew and Madsen,[1] the gonadal dose, without protection, amounted to 0.4 mr.; however, with shielding, it was possible to reduce this to 0.07 mr. Assuming that the fetus is exposed to no more than that exposed to the gonads, the mr. dose is rather minimal. This can be greatly decreased by such methods as protecting the patient with a lead apron, thus exposing only the chest; of taking only a postero-anterior view; using thicker aluminum filtration, 2.5 mm. rather than 0.5 mm.; replacement of the par-speed screens with hi-speed screens; and the use of higher speed roentgenographic film. One should also restrict taking x-rays on pregnant patients before three months gestation. However, even a minimum radiation dose and even the slightest risk must be justified by the results obtained in the examination concerned.

Conclusions

Upon evaluating the statistics of the study, three of 2,262 pregnant patients were found to have previously unknown tuberculosis. This is an incidence of .13 per cent, which is rather small. However, also involved is each patient's child as well as those in association with the mother, such as relatives and other patients, which can lead us to a much more significant factor. Accordingly, we find routine chest radiography of pregnancy justifiable in spite of man's previous futile attempts to determine adequately and correctly any future unwanted results.

It would also seem reasonable that maternity hospitals whose patients, to some extent, are selected on the basis of poor social conditions should require that such an examination be routinely performed prior to admission.

Summary

1. Prenatal care is imperative to the field of obstetrics. Routine roentgenologic examinations of the chest play an important part in this care.

2. A survey of routine chest minifilms was made on 2,262 patients taken during prenatal examinations. Three cases of active tuberculosis were discovered.

3. The leukemogenic factor of diagnostic irradiation is discussed. It is concluded that the dosage to the fetus and gonads is insufficient to warrant great concern when proper precautionary measures are carried out.

4. Advocated methods for reduction of irradiation over the body of the patient and fetus when taking routine x-rays are outlined.

5. Use of routine chest x-rays as part of the prenatal care of patients at maternity hospitals is advisable, especially when patients come from poor social and economic environments.

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Alcoholics deserve careful attention to their general health and to their genetic background. Evidence of the effect of alcohol on their health should be presented to them.

An Approach to a Chronic Alcoholic

H. Marvin Pollard, M.D.
Ann Arbor, Michigan

IN OUR own laboratory,[1] it has been shown experimentally that there are changes in enzyme activity in rat liver attributable to alcohol. It is also suggested from our recent studies[2] that patients with liver complications from alcoholic cirrhosis of the liver are subject to complications to a much greater degree in organs other than the liver, specifically with reference to such conditions as cancer of the esophagus, diabetes mellitus, and coronary occlusion. The ability of chronic alcoholics to develop chronic recurrent pancreatitis is well known, causing damage to the pancreas and serving as a factor in the development of diabetes.

These complications experienced by individuals who consume an excessive amount of alcohol are of great significance to the physician who must see these individuals as patients and should lead him to an investigation of their entire health picture, even though excessive consumption of alcohol seems to be the predominant clinical feature. In the initial care of chronic alcoholics the most immediate and imperative item is a thorough physical examination, including a chest x-ray, evaluation of the cardiovascular status, complete evaluation of the gastrointestinal tract, complete liver function studies, metabolism, and a glucose tolerance test.

Genetics is becoming an increasing factor in our understanding and evaluating individuals who develop chronic alcoholism. For example, it is now well known that most male chronic alcoholics are devoid of hair on the chest, but of more significance is the fact that they have never had hair on the chest. As one probes into their background one frequently finds that their fathers had the same absence of hirsuitism on the chest, as well as some or all of their brothers. In the course of questioning females who are alcoholics, we are becoming increasingly aware that when they are familiar with the element of hirsuitism in their fathers or brothers, that here too there has been a lack of hair on the chest in some of them. This emphasizes the point that there appears to be a genetic factor in the development of the condition known as chronic alcoholism. Just what the specific genetic defect is has not been established, but the absence of hirsutism is a physical lead to its presence, indicating a possible intolerance of alcohol.

By evaluating the entire health status of an alcoholic, by being aware of any physical abnormality, by being aware of genetic factors, the physician can sometimes appeal to the one item which is of importance to an alcoholic, this being the alcoholic's own health. Frequently, he will listen to a doctor if he is made aware of the fact that his own health is being impaired by his overindulgence in alcohol. He may not concern himself about the welfare of others and how his drinking affects his family, his job, or even his own finances, but he will often listen to and heed advice if he is cognizant of damage being brought about to his own physical state.

From the Department of Internal Medicine (Section of Gastroenterology), The University of Michigan Medical School, Ann Arbor, Michigan.

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Can We Do More in 64?

By Edgar E. Martmer, M.D., Chairman
County Societies Committee of The MSMS Council

Democracy is defined as government in which the supreme power is retained by the people and exercised directly, or indirectly, through a system of representation.

The medical profession of the United States of America is an outstanding example of Democracy in action, in which both professionally and as a citizen, each physician participates in a continuing effort to improve the quality of medical care and provide for its distribution so as to enable all citizens of the United States to enjoy the best medical care available in the world.

As the Officers of the component County Medical Societies which constitute the Michigan State Medical Society and members of committees review their efforts during the past year in preparation to turning the responsibility for continuing the many programs which the medical profession sponsors to their colleagues, who will assume the direction of such programs during the coming year, they are justified in pointing with pride to their accomplishments.

* * *

WE WISH it were possible to say "Thank you for a job well done" to each of them individually.

To the new officers and committee members we extend our congratulations for their willingness to accept the responsibilities of such appointments and assure them of our desire to assist in any manner possible.

The individual physicians of Michigan as well as those who serve as Officers and Members of Committees of the County Medical Societies are urged to continue their great interest in community activities. As Americans we serve our communities both as citizens and physicians. Wherever and whenever possible we should participate in any and all programs which are designed to make the United States a better place to live in.

* * *

AS PHYSICIANS, we should continue and wherever possible increase our efforts to maintain the high degree of medical knowledge which characterizes the American physi-

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cian by utilizing all methods of postgraduate education to the fullest extent.

As we review the past year with pride, let us resolve to make 1964 an even more successful year. If each of us makes a firm resolution to endeavor to do so, we shall.

Chamber Music

Sweet music for the ears of American medicine was provided by the recently published "Policy Declarations" for 1963-64 from the Chamber of Commerce of the United States. This organization is one of the several forces working to preserve and strengthen the American way of life and its Policy Declaration includes a statement on medical care which is of interest to every physician. The medical care declaration, adopted by the U. S. Chamber members, states that:

> "Legislation designed to supplement voluntary welfare efforts in financial medical care for those unable to provide it for themselves, regardless of age, should preserve the principles of local participation and determination."

In the introduction to the Chamber booklet, Arch N. Booth, Executive Vice-president, effectively explains that "These declarations of policy reflect the American philosophy of enterprise favoring limited government and the motivation of production by incentives within the framework of a free competitive market economy. They are timely in that they apply to current problems, but they rest upon durable principles which must be upheld in the interest of our national character, our productive strength and our continuing prosperity."

The Michigan State Medical Society has been a member of the National Chamber of Commerce for many years. The MSMS Council this year increased its contribution because of "the United States Chamber's support in projects of interest to organized medicine."

When Professional Education Fails

By Park W. Willis, III, M.D.
Ann Arbor

At the moment there are major opportunities for prevention of each of the three most common types of cardiovascular disease—those due to hypertension, rheumatic fever and atherosclerosis.

This has been most strikingly demonstrated by the 44.6 per cent decline in deaths due to hypertension and the 21.8 per cent decline in deaths due to strokes in 45- to 64-year-old men in this country over the 1950-1960 decade. Although possibly due in part to changes in diagnostic custom, this decline seems real and probably results from a number of factors. The decrease can properly be hailed as a tribute to the development, availability and free, often erratic, use of a variety of agents that have, to a greater or lesser degree, the capacity of lowering elevated systolic and diastolic pressure levels. It is also undoubtedly the result of a greater demand by the public for frequent physical examinations, a general awareness of the implications of high blood pressure and of the increasing diagnostic and therapeutic attention paid by physicians to blood pressure elevations of moderate degree.

In this area of successful disease prevention, professional education programs of all sorts, both at the undergraduate and graduate levels, can rightfully claim a large part of the credit.

Primary prevention of hypertension itself is not yet possible, since methods of detection of susceptibles are in their infancy, and the significance of labile or very mild blood pressure elevation is still in doubt.

In a second major area—rheumatic fever and rheumatic heart disease—secondary prevention has also been effective but is much less satisfying an accomplishment, since susceptibles *can* be identified and *primary* prevention should be possible with a resultant virtual disappearance of rheumatic heart disease. In the late 1940's, with the availability of penicillin,

there was an immediate drop in the incidence of acute rheumatic fever, and this decline continued in several of the large population centers until the mid or late 1950's. Since then new cases have appeared at a fairly constant rate, and it is the impression of many clinicians that rheumatic heart disease is still being seen as frequently in adults as in the past. Further success in the primary prevention of rheumatic fever will depend upon the widespread and indiscriminate use of penicillin (which, as one distinguished professor has said, may do infinitely more good than harm) or upon an aggressive program of readily available, community-wide, low-cost, rapidly reporting services for the identification of group A beta hemolytic streptococci. Such programs have been very successful in some communities and so little used by physicians in other areas that appeals have had to be directed to the public in the form of such slogans as: "Does Your Child Have A Sore Throat? Get A Throat Culture." In such instances of failure of professional education programs, exhortations directed to the general public may be successful and may eventually result in additional significant accomplishments in the primary prevention of rheumatic fever. An understanding by laymen of the need and value of throat cultures in the prevention of rheumatic fever will predictably lead to more ready acceptance of advised throat cultures and at times a request for this type of study when it has not been suggested by the physician.

In contrast to the encouraging record of accomplishment in secondary prevention in hypertension and stroke and primary prevention in rheumatic fever is the experience with coronary artery disease, where an increase of 4.3 per cent was recorded in the group mentioned above.

The traditional concept of curative therapy, best exemplified by the treatment of infectious diseases where relatively complete reversal of a pathologic process is possible, is quite different when applied to coronary artery or other atherosclerotic vascular disease where cures as such do not exist, and where the physician often has palliation as his major goal, and the relief of symptoms of an unaltered basic process as his measure of "success." In such situations, as usual, primary prevention has much more appeal and long-term significance than secondary prevention. Since many of the factors which predispose individuals to atherosclerotic coronary artery disease have been identified and since some of these are controllable, the increasing frequency of deaths due to coronary artery disease can be interpreted as evidence of failure in another area of professional education.

How can this failure of professional education best be remedied? A more intensive appeal to physicians might be effective, but perhaps the time is nearing when an aggressive lay education campaign can be laid out, aimed at the primary prevention of coronary artery disease and other types of atherosclerosis. Indeed, the recent publication of one guide to coronary artery disease for the public allows an individual to estimate, with some help from his physician and the laboratory, his chances of developing coronary artery disease, and may be a significant step in the history of development of such a public education program. Current studies may allow resolution of some of the uncertainties concerning the role of diet in the genesis of coronary artery disease and would help to provide some of the most important information needed to define an effective and comprehensive coronary diesase prevention program.

Advertising Appreciated

Advertising is a part of the American way of life and an essential component in the competitive free enterprise system. We often take it for granted and perhaps need to be reminded of its importance to us. The participation by advertisers makes The Journal of the Michigan State Medical Society possible. Use the advertisers index and, where appropriate, mention to the detail man that you saw his company's participation in The Journal.

We wish to thank each Journal advertiser for his continued support for 1964.

MSMS Centennial Series

Ambitious Public Education Program In 1935 Helped Tell Medicine's Story

By William J. Stapleton, Jr., M.D.
Detroit, Michigan
MSMS Historian

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number and will continue through August, 1965.*

1935

The Joint Committee of MSMS and other health and educational organizations, continued its efforts with as many as 600 physicians and dentists lecturing before schools, PTAs, and other lay groups to tell the story of private medicine.

Seven years ago, the *Detroit News* requested the Joint Committee to undertake a health column. The column reached from one to two million readers a year through the *Detroit News* and other state papers which utilized the column.

At a meeting of the Joint Committee on November 7, 1935, four standing committees were created:

1. A committee on Scientific Programs, to select health subjects of greatest social significance.
2. On Health Education in schools.
3. On Adult Health Education.
4. On Administration, which will administer the program, keep the records, and in conjunction with the Executive Committee select the speakers best qualified.

The Wayne County Medical Society Bureau completed its first year of service on February 16, 1935. The Bureau was a plan of credit to patients which enabled them to liquidate their debts to the physician and surgeon, hospital, dentist, or nurse under a post-payment plan. It had many merits; besides being satisfactory to the patient, it had the further advantage of retaining medical practice in the hands of the profession.



Richard R. Smith, M.D.
President 1934-35

The afflicted Child Act was passed in the closing hours of the Legislature and was signed by the Governor on May 29, 1935. The law allowed a Probate Judge to send those afflicted children who come under this law to local hospitals and allows compensation to the attending physician or doctor. The cost of the medical and hospital care was assumed by the state and paid through the hospital. The operation of this act was placed under the control of the Crippled Children Commission.

The following postgraduate courses were given in Detroit: Proctology; Genito-urinary Diseases; Gynecology, Obstetrics, and Gynecological Pathology; General Medicine, Traumatic, Emergency, and Minor Surgery; and Pediatrics. The following courses were given in Ann Arbor: Electrocardiography, Ophthalmology and Otolaryngology, Roentgenology, and Diseases of the Blood and Blood-Forming Organs; and Surgery. The enthusiastic response to the teaching program given in Grand Rapids, Flint, and Battle Creek (jointly) in 1935, at which 796 doctors attended, warranted continuation of this program, as well as extension to other parts of the state. Accordingly, postgraduate programs were conducted in Battle Creek-Kalamazoo (jointly); Grand Rapids; Flint, Bay City; Manistee, Cadillac, and Traverse City (jointly); and Alpena-Petoskey (jointly).

A number of important medical meetings were held in Detroit. The Federation of American Societies for



The Author
WILLIAM J.
STAPLETON, JR., M.D.
MSMS Historian

Experimental Biology heard many papers on the important relation to clinical medicine. . . . The Radiology Society of North America and the International Assembly of the Inter-state Postgraduate Medical Association of North America also met in Detroit.

An important announcement that affected the activities of MSMS was the appointment of an executive secretary—The Council in November appointed Wm. J. Burns, who had served as executive secretary of the Wayne County Medical Society and the Toledo Academy of Medicine. The MSMS offices were moved to 2020 Olds Tower in Lansing.

The Cancer Committee carried out an ambitious program. It included:

1. Cancer education in high schools and PTAs.
2. Utilization of newspapers and the radio as media for presenting cancer facts to the laity.
3. Extension of postgraduate medical education along cancer lines.
4. Investigating the possibilities of obtaining a fact-finding survey of cancer in Michigan.

Other MSMS internal matters included action by the House of Delegates to establish a Section on Radiology. . . . The restoring of the MSMS dues to their former figure of $10 for 1936. . . . And the gain in MSMS membership from 3,160 in 1933 steadily to 3,393 in 1935.

President was Richard R. Smith, M.D., of Grand Rapids.

Michigan Medical Meetings

Genesee County Medical Society "Alcoholism Day," February 19, Hurley Hospital, Flint.

Third Annual Thyroid Workshop, Woman's Hospital, February 22, Detroit.

Michigan Heart Association "Heart Day," February 22, Statler-Hilton, Detroit.

County Secretaries PR Seminar, February 27, Jack Tar Hotel, Lansing.

Michigan Clinical Institute, March 11-13, Sheraton-Cadillac Hotel, Detroit.

Michigan State Medical Assistants Educational Seminar, March 11, Statler-Hilton, Detroit.

Michigan State Nurses Association, "Operating Room Nurses Institute," March 16-18, Statler-Hilton, Detroit.

Wayne Obstetrics-Gynecology Residents Day, March 25, Wayne County Medical Society, Detroit.

National Hospital Week, May 6-8.

MSMS Maternal and Perinatal Mortality Workshop, May 14-15, Gull Lake Conference Center, Battle Creek.

Wayne State University Clinic Day and Alumni Reunion, May 20, Detroit.

Michigan Hospital Association, 45th Annual Convention, June 14-16, Grand Hotel, Mackinac Island.

1964 Michigan Clinical Institute Ancillary Meetings

Woman's Auxiliary to the Michigan State Medical Society
March 12, Pick-Fort Shelby Hotel, Detroit
From 10 a.m. to 4 p.m., with luncheon meeting.

Michigan State Medical Assistants Society
March 11, Statler-Hilton Hotel, Detroit
From 10 a.m. to 3:30 p.m. with luncheon meeting.

Operating Room Nurses, Michigan Nurses Association
March 12 and 13, Statler-Hilton Hotel, Detroit.
From 9 to 12 and 2 to 4 each day.
Luncheon on March 13.

Michigan Chapter, American College of Chest Physicians
March 11, Sheraton-Cadillac Hotel, Detroit
Evening dinner meeting.

Michigan Academy of Plastic Surgery
March 11, Detroit Athletic Club, Detroit
6 p.m. dinner and business meeting.

Michigan State Neurosurgical Society
March 11, Sheraton-Cadillac Hotel, Detroit
4 p.m. business meeting.

Wayne State University College of Medicine Alumni Association
March 11 and 12, Sheraton-Cadillac Hotel, Detroit
From 9 a.m. to 5 p.m., Hospitality Room

University of Michigan Medical Center Alumni Society
March 12, Sheraton-Cadillac Hotel, Detroit
From 5 to 7 p.m., Reception

MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Radiological Health Programs

In carrying out a part of its statutory responsibilities to protect the health and lives of the people of Michigan, the Michigan Department of Health engages in various activities related to radiological health. The following is a progress report on a nuclear power reactor surveillance program and a dental radiological health program.

Nuclear Reactor Surveillance

Since the Atomic Energy Commission began to promote the commercial use of nuclear power in 1955, two power reactors have been built in Michigan: the Enrico Fermi reactor built by the Power Reactor Development Corporation near Monroe and the Big Rock Point power reactor built by Consumers Power Company near Charlevoix. The state health department has worked closely with both companies in reviewing safety factors during the construction of the reactors. In addition, the department has established an environmental surveillance monitoring program as a means of determining whether or not the safety mechanisms are operating properly.

The monitoring program was established with the following objectives:

1. Establish natural pre-operational levels of radioactivity from background and atomic test debris around the plant sites and populated areas.
2. Establish standard operating procedures for sampling, laboratory separations, and counting of samples to provide a basis for comparison of sample results with those of the Power Reactor Development Corporation, Consumers Power Company, and other agencies.
3. Establish levels of radioactivity in three areas of the state so that abnormal trends can be detected in one particular area.
4. Protect the health of the workers at the reactor sites and the population at large by taking steps to minimize the hazards should a "build-up" of radioactive materials be detected or an accident occur.

Air sampling, soil evaluation, iodine vapor sampling, mouse sampling, vegetation sampling, and rain collection are included in the surveillance program.

Air is drawn through filters and air particulant samples counted for gross beta activity.

Rain samples are collected in polyethylene containers by means of polyethylene funnels and measured in microcuries per milliliter of precipitation.

Mice are caught around the air sampling stations with common snap traps. They are weighed, the skin is removed, and after the thyroids have been removed, the carcasses are digested in concentrated nitric acid. A radioactive barium-strontium determination is performed on the carcasses and thyroids are analyzed by a scintillation counter.

Vegetation samples consisting of plants such as corn, soy beans, and grass are collected on a weekly basis during the growing season and gross beta activity and barium-strontium and calcium determinations are made.

Soil samples are collected at monthly intervals and gross beta activity is determined per gram of dry soil.

Milk is collected on a weekly basis from dairy plants in the vicinity of the reactors as well as in five other localities in the state. The milk is checked for Strontium 90, Iodine 131, Cesium 137, Potassium 40, and Barium-Lanthanum 140 activity.

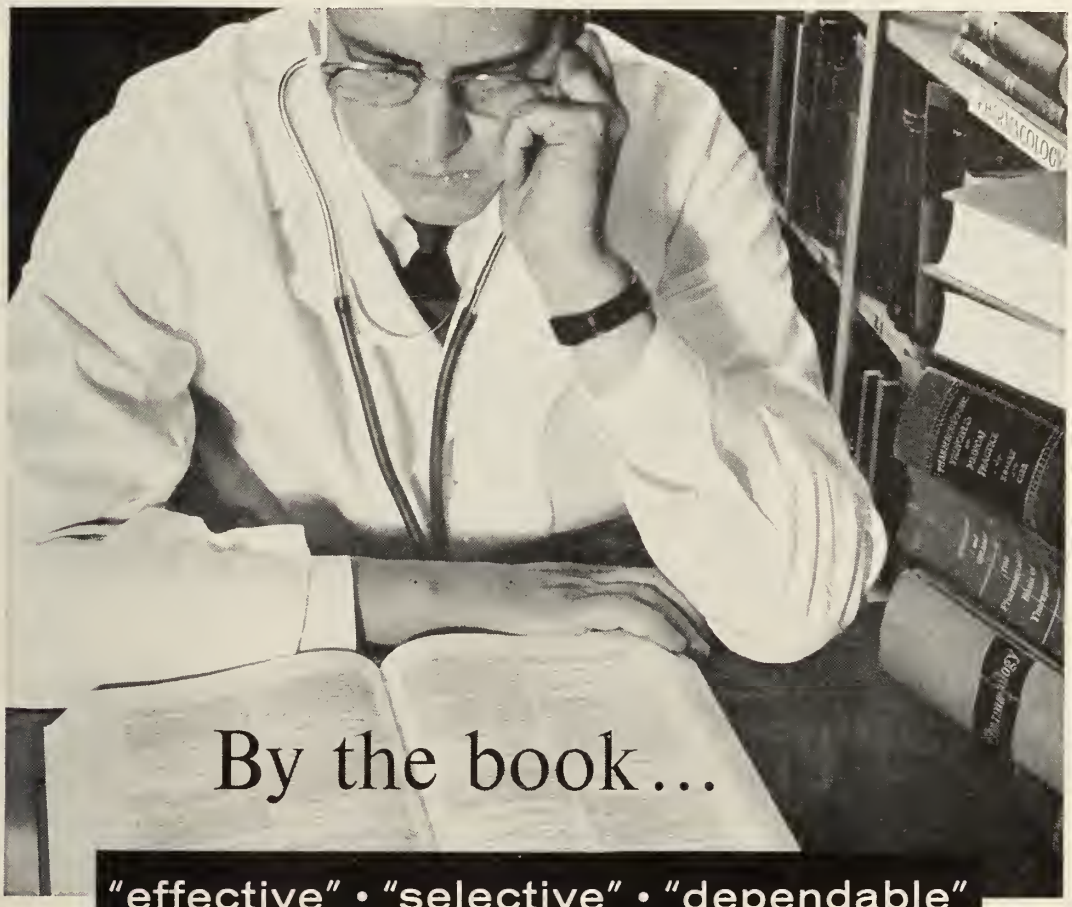
In addition, a program of monitoring external gamma radiation by the use of film badges was initiated during the past year.

The results to date on all samples taken merely indicate normal fluctuation in background radiation due to atomic bomb test debris. The monitoring program has now been in operation about five years and the program has satisfied objectives up to the present time.

Dental Radiological Health Program

To help assure the most efficient and safest use of x-rays in dental offices, consistent with satisfactory diagnostic results, a radiological health program was carried out by the department in cooperation with the Michigan State Dental Association, the United States Public Health Service, and the Detroit Department of

(Continued on Page 158)



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These qualities have won such wide recognition in standard texts on pharmacology and therapeutics that to prescribe Pro-Banthīne (propantheline bromide) is truly to prescribe "by the book."

The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime.

Side Effects And Cautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur with Pro-Banthīne (propantheline bromide). It is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthīne (propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

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"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. *27*:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

SK&F *Smith Kline & French Laboratories*

Say you saw it in the Journal of the Michigan State Medical Society

Five Resolutions Offered By MSMS at Portland

By William A. Hyland, M.D., *Chairman, MSMS Delegation to AMA*

The Michigan delegation to the AMA House of Delegates' meeting in Portland submitted five resolutions.

The first one was commendation for the excellent work of Dr. Edward R. Annis who has so largely raised the impression of the American Medical Association throughout the land by his forceful and persuasive manner in telling the American Medical Association story. A tremendous standing ovation was rendered by the House to him with considerable credit to Michigan for its thoughtfulness in recommending the resolution.

The second Michigan resolution urged compulsory social security for all members of the American Medical Association. Georgia immediately followed with a resolution urging the House not support Social Security for physicians. This resolution received quite a hand, and we knew what was to be the outcome of our resolution on the same subject.

Later, the AMA delegates reaffirmed the policy of opposing the inclusion of self-employed physicians under Social Security.

Our resolution requesting a better definition of the term of Public Health was referred to the Board of Trustees for study. Later, a report was made to the House of Delegates. The report declared:

"This resolution requests clarification of the statement incorporated in its second whereas which reads: The 1962 American Medical Association House of Delegates supplemented its former concept of public health activities delineated above by stating Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts. It includes those arrangements whereby the community provides medical services for special groups of persons and is concerned with prevention and control of disease, with persons requiring hospitalization to protect the community, and the medically indigent.

"Your reference committee calls the attention of the House to the fact that this statement was first passed by the House in 1948 and was reaffirmed in 1962 after a detailed report on it was presented to the Board of Trustees and House of Delegates by the Committee on Medical Facilities of the Council on Medical Service. Your reference committee believes that the appropriate method of providing clarification of the statement is to submit it to the Board of Trustees for implementation of the request desired in the resolution. Your reference committee, therefore, recommends approval of the resolution and implementation by this method."

The resolution was adopted.

The Resolution passed by the MSMS House of Delegates about Government subsidy for prepaid health insurance for the needy was introduced as instructed.

The AMA reference committee carefully considered all aspects of the resolution and brought this report to the AMA Delegates:

This resolution presented by the Michigan delegation was the subject of extensive discussion by those appearing before your com-

A complete report—covering the AMA House of Delegates, Scientific Sessions, What the AMA Has Done in the Past Year and What Is to Come—has been sent to every member of MSMS House of Delegates. Copies are available from the MSMS Headquarters.



mittee. After careful consideration of the views presented, your Reference Committee recommends that this resolution not be adopted.

"Your committee has concluded that the two elements of Resolution 25, tax credits and government subsidies for prepaid health insurance, may be implemented under other mechanisms. With respect to tax credits, existing policy of the Association, as set forth in the Committee's recommendation on Supplementary Report P above, amply provides for the principle.

"With respect to government subsidies for health insurance, existing Association policy wisely would limit such aid to those in need. Testimony before your committee revealed that experience in a number of states has shown that prepaid health insurance may be provided under Kerr-Mills programs. Your Reference Committee, therefore, earnestly recommends that the state medical societies explore the advantages of implementing Kerr-Mills programs in a manner which will permit the care of beneficiaries under voluntary health insurance programs."

The resolution was not adopted.

Michigan's final resolution commending the Board of Trustees and Executive Office for sending to delegates results of the Board of Trustees meetings between the two meetings of the Association was widely acclaimed.

The AMA reference committee reported as follows

"Your reference committee takes pleasure in joining with the Michigan Delegation, and we are sure with the delegates from all other states, in commending the Board of Trustees and Executive Office for instituting and distributing the summaries of major actions of meetings of the Board, consequently, your reference committee recommends approval of the resolution as submitted."

This resolution was adopted.

The Michigan delegates discussed our resolutions with many of the delegates, in fact, the Chairman of each delegation was contacted and a heavy job of selling was put on but they all do not have the same feeling as we have. As previously stated in the reports, the House membership covers every section of the country and the feeling in different areas is at times very dissimilar.

MSMS Representatives

MSMS delegates and alternates who attended the Portland meeting included Doctors Sidney Adler, B. M. Harris, G. B. Saltonstall, E. E. Martmer, R. E. Rice, J. R. Heidenreich, O. J. Johnson, L. R. Leader, George W. Slagle, D. N. Sweeny, Jr., and William A. Hyland, Chairman.

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Negro physicians, revision of the American Medical Association Constitution and Bylaws, voluntary health agencies and blood banks were among the other major subjects acted upon by the House of Delegates.

The House approved a Board of Trustees proposal that the American Medical Association Education and Research Foundation undertake a "comprehensive program of research on tobacco and health."

Agreeing that many gaps exist in knowledge about the relationship between smoking and health, the House declared that the study should be "devoted primarily to determining which significant human ailments may be caused or aggravated by smoking, how they may be caused, the particular element or elements in smoking that may be the causal or aggravating agent, and methods for the elimination of such agents."

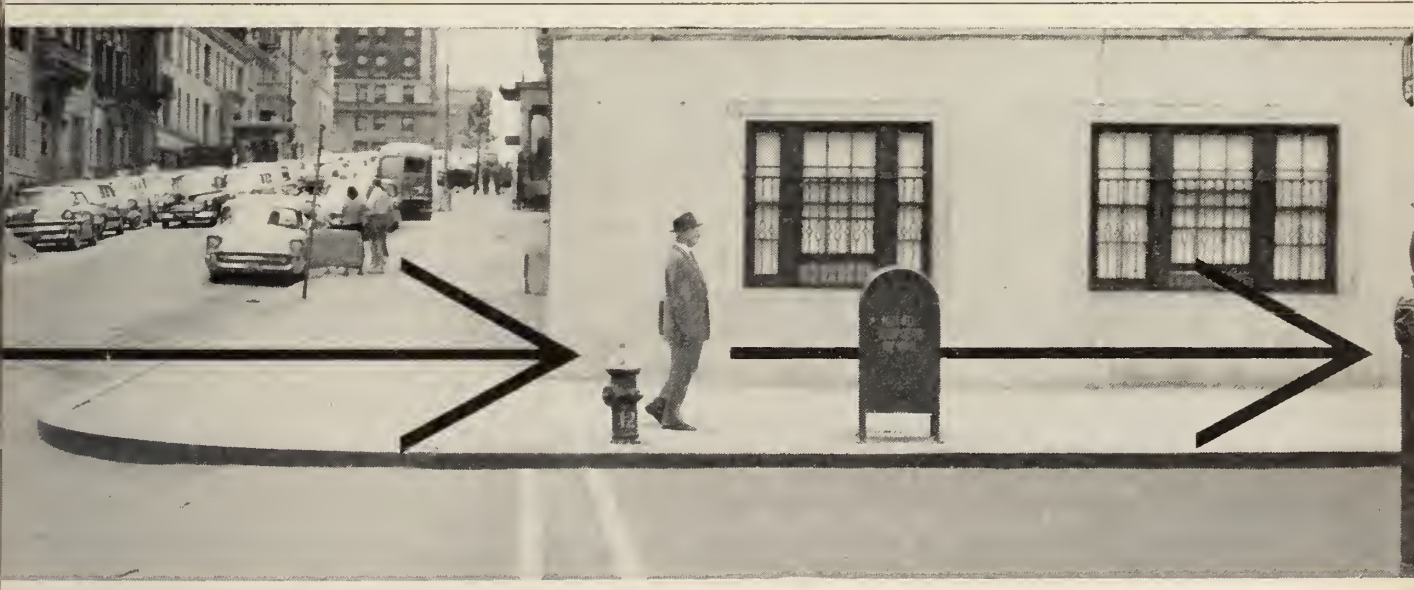
The House considered two proposals related to Negro physicians.

In adopting an AMA Board report, the House declared that "members of the medical staff of every hospital, where the admission of physicians to hospital staff privileges is subject to restrictive policies and practices based on race, be urged to study this question in the light of prevailing conditions with a view to taking such steps as they may elect to the end that all men and women professionally and ethically qualified shall be eligible for admission to hospital staff privileges on equal basis, regardless of race."

In both its approval of the Board report and its rejection of the proposed resolution—which would have denied the rights and privileges of AMA membership to members of any state or county society which refuses membership to any qualified physician because of race, religion or place of national origin—the House reaffirmed 1950 and 1952 policy actions on this subject. The 1950 resolution urged that "constituent and component societies having restrictive membership provisions based on race study this question in the light of prevailing conditions with a view of taking such steps as they may elect to eliminate such restrictive provisions."

The House approved comprehensive revisions and rearrangements of the Association's constitution and bylaws as submitted by the Council on Constitution and Bylaws.

In approving an AMA Board report on professional relationships with voluntary health agencies, the House declared that "the AMA maintain its policy of neither approving nor disapproving national voluntary health agencies." It also agreed "that the AMA, through its



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MICHIGAN NATIONAL BANK BUILDINGS



346

Committee on Voluntary Health Agencies, maintain its position of offering guidance on medical aspects of national voluntary health agencies."

Blood Bank Statement

The House adopted a policy statement pointing out that in recent years there has been a dramatic growth of blood banking facilities in the United States and declaring that "it is highly essential that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, the approval of the county or district medical society and, therefore, should be coordinated with existing approved blood banking facilities." The House also approved a floor amendment stating that since a blood bank can well be considered a medical facility, the top authority in a blood bank should be a physician.

In considering a wide variety of reports and resolutions, the House also:

Expressed gratification that the work of the Committee on Medicine and Religion has received widespread acceptance and support from state and county medical societies, religious groups and other related organizations;

Received a report on the AMA Members Retirement Plan and urged physicians to act quickly if they are to exercise their rights under Public Law 87-792 during 1963;

Urged that the term "the aging" be used instead of "the aged" in all statements by the medical profession regarding older persons;

Earnestly recommended that the state medical societies explore the advantages of implementing Kerr-Mills programs in a manner which will permit the care of beneficiaries under voluntary health insurance program;

Resolved that the AMA attempt to have removed from the Kefauver-Harris Amendment those provisions which authorize the U. S. Food and Drug Administration to determine the effectiveness of drugs;

Agreed that a short form medical record may be used in cases of a minor nature, in general, should apply to hospital stays of 48 hours or less;

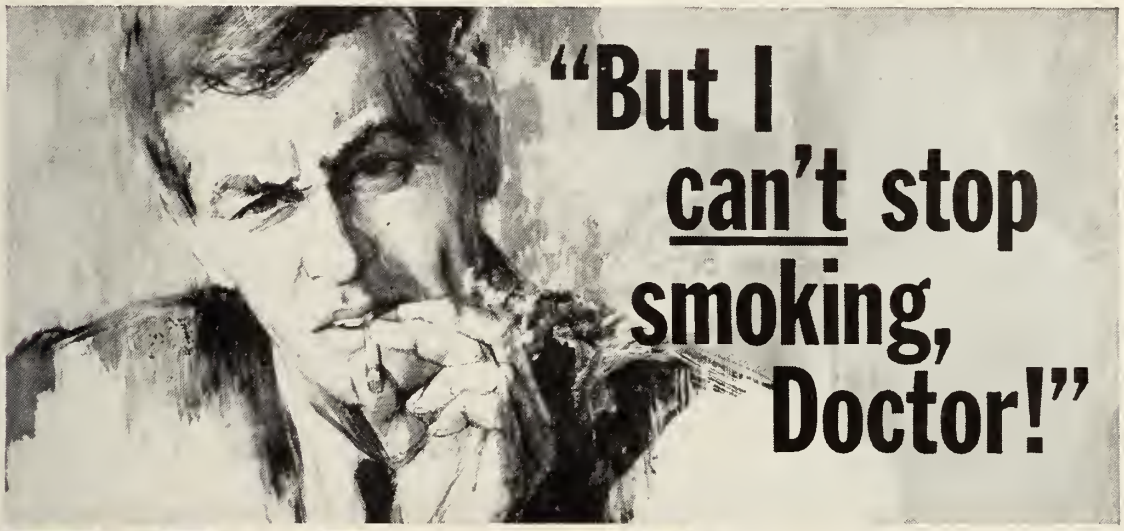
Urged all American Medical Association members to continue to support the Woman's Auxiliary so that it can be successful in increasing its membership, raising more revenue and broadening its range of activities.

Former Postmaster Day Opposes Fedicare Plan

Former new-frontier Postmaster General J. Edward Day has warned in Nation's Business that the country cannot afford the Administration's medicare plan. He

(Continued on Page 146)

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1st week: 1 pastille every 1 to 2 hours for a maximum of 12 pastilles daily. *2nd week:* 1 pastille every 3 hours. *3rd week:* 1 pastille every 4 hours. *4th week:* 1 pastille every 4 to 6 hours. *Thereafter* 1 pastille may be taken at infrequent intervals whenever necessary. In some instances there may at first be a slight astringent burr of the tongue and throat. This will usually disappear as treatment with NIKOBAN Pastilles progresses and is no cause for concern.

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Formulation: Each NIKOBAN Pastille contains 0.5 mg. lobeline sulfate in a pleasant tasting spiced-cherry base.

Availability: In packages of 50 pastilles.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, Macmillan, 1960, Ed. 2, pp. 620-622; 2. Edmunds, C. W.: J. Pharmacol. and Exper. Therap., 1:27, 1909; 3. Hazard, R. and Savini, E. Gand., 92:471, 1963. 4. Dorsey, J. L.: Ann. Int. Med., 10:628, 1936; 5. Rasmussen, K. B.: Ugeskr.laeger, 118:222, 1956; 6. Ejrup, B.: Sven. lak. Tid., 53:2634, 1956; 7. Jochum, K. and Jost, F.: Munch. med. Wchnschr., 103:618, 1961; 8. Jost, F. and Jochum, K.: Med. Klin., 54:1049, 1959; 9. Smoking and Health, Summary and Report of the Royal College of Physicians of London on Smoking. New York, Pitman, 1962.

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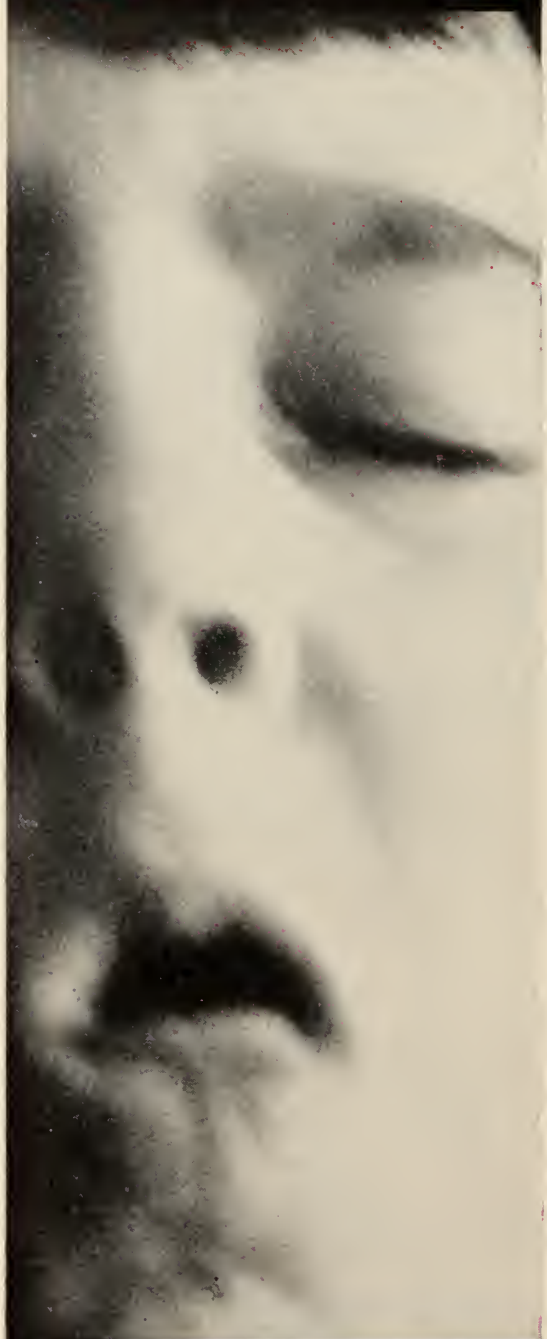
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Former Postmaster Day Opposes Fedicare Plan

(Continued from Page 144)

points out that federal Social Security benefits now total over $13 billion yearly, with payments of $25 billion projected in the near future. The extra expense of medicare, remarks Day, "would make the total load of financing the Social Security program completely out of hand."

Nebraska Representative Says Fedicare Is "Phony"

The Ways and Means Committee has again started hearings on the King-Anderson medical bill. This is a phony bill, does not do what it purports, would cost billions of dollars to be paid for by the employes now working through increased Social Security taxes and would bring socialization to our medical profession. America does not want this type of program; only the social planners want it. Our taxpayers want less government, not more. Although it is not probable that this bill will emerge from committee, I intend to watch it closely and to continue my fight against its enactment.—REP. DAVE MARTIN (R.-Neb.)

Pfizer Journals Sent Overseas



More than 150,000 back issues of *Spectrum* medical publication of the Chas. Pfizer & Company, were sent through the U. S. Navy *Project Handclasp* for distribution overseas in areas needing medical literature. Shown overseeing the loading at the Navy Base in Bayonne, N. J., are left to right, Henry Nachtigall, M.D., World Medical Association; R. M. Rees, M.D., Pfizer; Capt. G. E. Miller, USN, and Gerald D. Dorman, M.D., also WMA.

PMA Voices Stand Against King-Anderson

In a statement filed with the House Ways and Means Committee, Pharmaceutical Manufacturers Association has re-stated its opposition to the King-Anderson bill for medical care of the aged under social security. PMA based its opposition on the grounds the plan could result in increased use of inferior drugs, would lower present high standards of health care, would put the Federal government into competition with private enterprise, and would undermine local responsibility and pave the way for national compulsory health insurance.

PMA President Austin Smith said that the King-Anderson plan would cost much more than its sponsors expect and that the Kerr-Mills act (for financing care of the medically indigent) is making good progress and should be given a longer trial.

Michigan Authors

D. H. Mosley, M.D., I. J. Schatz, M.D., G. M. Breneman, M.D., and **J. W. Keyes, M.D.,** Detroit, "Long-Term Anticoagulant Therapy," *Journal of the American Medical Association,* December 7, 1963.

C. J. France, M.D., C. Kouchy, M.D., K. Hergt, M.D., and **O. A. Brines, M.D.,** Detroit, "Relationship of Histology to Prognosis in Thyroid Carcinoma," *Archives of Surgery,* April, 1963.

B. C. Payne, M.D., Ann Arbor, "Function of the Audit Committee in the General Hospital," *Journal of the American Hospital Association,* December 1, 1963.

James C. Breneman, M.D., Galesburg, "A Formula for Predicting and a Device for Preventing Postoperative Thromboembolic Disease," *Angiology,* September, 1963.

Letter to the Editor

Dear Editor Tupper:

We want you to know that we appreciate the description of the AMA-ERF Loan Program that appeared in your December JOURNAL under the editorial heading of "Money and Medical Manpower."

Thank you for your interest and support, and please know that we appreciated the appropriate way the material was developed in your article.

Most sincerely,

E. M. STEINDLER, *Assistant Director,*
AMA Medical Education Loan Guarantee Program
Chicago, Illinois
January 3, 1964



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Voices Concern About Unsupervised Laboratories

By E. M. Knights, Jr., M.D.,
Michigan Society of Pathologists
Public Relations Committee Chairman

Unsupervised laboratories run by untrained technicians are a hazard to the unsuspecting patient, Rosser L. Mainwaring, M.D., emphasized recently. Dr. Mainwaring, Councilor of Michigan Society of Pathologists, pledged the full cooperation of Michigan's pathologists in helping the Detroit Health Department in its current crackdown on unscrupulous clinical laboratories.

Michigan's hospitals have laboratories which are, for the most part, directed by pathologists who have received five years of postgraduate training in pathologic anatomy and clinical pathology after graduation from medical school. In addition they employ registered medical technologists in key positions; to obtain registration medical technologists must now have three years of college training, one year of internship in an approved hospital laboratory training course, and then pass an examination given by the Registry of Medical Technologists of The American Society of Clinical Pathologists.

While some private clinical laboratories are pathologist supervised and maintain standards of quality control similar to those insisted upon in hospitals, many private laboratories are run by persons with inadequate training, utilizing poor equipment and unsatisfactory methods.

Recognizing the potential danger to the patients and the importance of proper diagnosis in the treatment of disease, some states have already ruled that clinical pathology, or the performance of laboratory tests on humans, is the practice of medicine and must be supervised by licensed physicians. Thus, while the important contributions of clinical biochemists, microbiologists, medical technologists and other paramedical personnel are fully recognized, the final responsibility for both diagnosis and treatment rests with the practicing physician.



Steiner, Irvin Direct State Health Council

S. D. Steiner, M.D., Detroit, medical director of General Motors Corporation, is the new president-elect of the Michigan Health Council, chosen at the recent annual meeting.

Earle A. Irvin, M.D., Grosse Pointe, medical director of Ford Motor Company, was installed as president for 1964. Doctor Irvin is a past-president of the Industrial Medical Association of the United States, the Michigan Industrial Medical Association, and the Michigan Heart Association. Hugh W. Brenneman, executive director of the Michigan State Medical Society, and Edwin L. Harmon, M.D.,

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Detroit, medical director of Michigan Hospital Service, were re-elected secretary and treasurer, respectively. John A. Doherty, executive secretary of the Council, was elected to the newly-created office of assistant treasurer.



S. D. STEINER, M.D.



E. A. IRVIN, M.D.

Elected to the board of trustees were Harry Lipson, Detroit, General Manager of WJBK-Radio; and Joseph R. Lentini, M.D., of Grand Rapids. Re-elected for three-year terms on the board were E. Gifford Upjohn, M.D., of Kalamazoo, The Upjohn Company; Otto K. Engelke, M.D., Ann Arbor; Mrs. Marjorie Karker, Lansing, Coordinator, Farm Bureau Women's Activities; Marvin L. Niehuss, Ann Arbor, University of Michigan; and Gordon H. Scott, Ph.D., Detroit, Wayne State University.

The Michigan Health Council honored William J. Burns, who retired December 31 after nearly 30 years as executive director of the Michigan State Medical Society. Doctor Scott, outgoing president of the Council, presented Mr. Burns with a gift in appreciation of his distinguished service with medical and voluntary health organizations resulting in better health care and programs for Michigan citizens. Mr. Burns was one of the early officers of the Michigan Health Council, serving as secretary from 1944 to 1947.

MSMAS Seminar, March 11, Spotlights Ruth Campbell, M.D.

Plans are being completed for the seventh annual Educational Seminar of the Michigan State Medical Assistants Society March 11, at the Statler-Hilton Hotel in Detroit.

The theme of the Seminar will be "It's A Woman's World." The annual L. Fernald Foster Lecture will be given by Ruth Campbell, M.D., of Detroit. Since the death of Doctor Foster in May, 1959, many very prominent doctors have contributed their time and talents to this memorial lecture including Drs. George Lowrey, Herbert J. Bloom and Donald Sweeney.

Other speakers on the program this year will be Viola Brekke, M.D., whose topic will be "The Role of Women in Medicine" and Mrs. Patricia Breen of

Merrill Lynch, Pierce, Fenner and Smith who will speak on "Women in Wall Street."

Registration and luncheon will be $5.50; the deadline for reservations will be March 4. Registrations are being taken by Mrs. Dolores Kobylka, 12061 Sorrento, Detroit 27. Please make checks payable to Mrs. Kobylka.

Miss Gwen Whitcomb will be chairman of the Seminar assisted as co-chairman by Miss Louise Rutila of Detroit.

All Medical Assistants are cordially invited to attend this one-day Seminar.

State Cancer Foundation Re-Elects Officers

Oscar D. Stryker, M.D., Mt. Clemens, has been re-elected to serve another year as president of the Michigan Cancer Foundation. Also returned were Brock E. Brush, M.D., Detroit, a vice-president, and James C. Cook, M.D., Detroit, secretary.

The annual meeting saw the selection of several new members of the board of directors, including Victor Curatolo, M.D., Mt. Clemens; Edwin DeJongh, M.D., Pontiac, and Harold C. Mack, M.D., Detroit.

Howard P. Doub, M.D., Detroit, foundation past president, was elevated to member emeritus of the board.

"Medical Assistant of the Year"



Mrs. Alberta Warmbold, of Paw Paw, received a plaque at the annual meeting of the Michigan State Medical Assistants Society as the "Medical Assistant of the Year." The presentation to the Van Buren County Medical Assistants Society was made by Carl Bennett, of the Medical-Dental Bureau, Flint.



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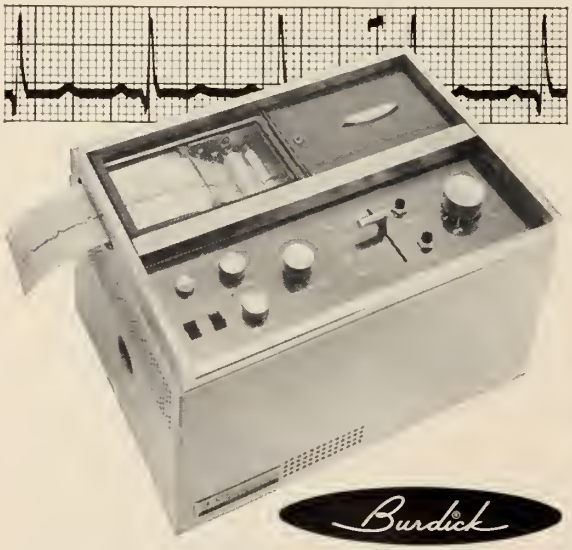
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Growing Assistants Society



Mrs. Mary Smith, as president of the Branch County Medical Assistants Society, accepted a trophy at the annual MSMAS convention as the county society with the largest increase in membership. The presentation was made by Glenn E. Millard, M.D., chairman, MSMS Advisory Committee to the MSMAS.

Kent Facility Accredited

The Kent County Board of Social Welfare has announced that Maple Grove Medical Care Facility has been approved for full accreditation by the Joint Commission on Accreditation of Hospitals.

Wayne Obstetrics-Gynecology Residents' Day, March 25

The Sixth Annual "Residents' Day" in Obstetrics-Gynecology will be held Wednesday, March 25, in the auditorium of the Wayne County Medical Society Building in Detroit. The all-day program will begin at 9 a.m.

The subjects to be treated during the day will include the indications for prophylactic oöphorectomy; some psychologic aspects of abdominal pain in women (with consideration of polysurgery addiction); the problem of urine stress incontinence; the chemotherapy of endometrial and ovarian carcinoma; the failure of establishment of proper respiratory exchange in the immediately newborn infant—causes and treatment; the evaluation of cardiac disease in pregnant women, and indications and contraindications for cardiac surgery in pregnant women, the value of continued follow-up of women treated for gynecologic cancer; and

(Continued on Page 154)

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Wayne Obstetrics-Gynecology Residents' Day, March 25

(Continued from Page 152)

the surgical treatment of cervical and uterine carcinoma.

At 8 p.m., the Milton A. Darling Memorial Lecture will be given by Langdon Parsons, M.D., Professor of Obstetrics and Gynecology at Boston University School of Medicine, Chief of Gynecology at the Massachusetts Memorial Hospital, and senior author of the textbook, "Gynecology."

Advance registration is requested so provision for the luncheon and dinner can be made. Luncheon tickets will be $1.35 and those for the dinner will be $5.25. To register, and to purchase meal tickets, in advance, please write to Charles S. Stevenson, M.D., Wayne State University College of Medicine, 1401 Rivard Street, Detroit 7. There is no registration fee.

Horn, Wolter to Lead Michigan Pathologists

Robert C. Horn, Jr., M.D., Detroit, was chosen as president-elect of the Michigan Society of Pathologists, at the recent annual meeting. James G. Wolter, M.D., Detroit, was installed as the new president.

Harold E. Bowman, M.D., Grand Rapids, will continue as secretary-treasurer of the Society, and as Councilor, ASCP.

The outgoing president was Rosser L. Mainwaring, M.D., Dearborn.

ARTERIO-VENOUS FISTULAE

(Continued from Page 127)

5. Biozzi, G., Benacerraf, B., and Halpern, B. N.: Quantitative study of the granulopectic activity of the reticuloendothelial system. British J. Pathol., 34:441, 1953.
6. Epstein, F. H., and Ferguson, T. B.: The effect of the formation of an arteriovenous fistula on blood volume. J. Clin. Invest., 34:434, 1955.
7. Blattberg, B., and Levy, M. N.: Reticulo-endothelial depression with superior mesenteric artery occlusion. Amer. J. Physiol., 204:899, 1963.
8. Blattberg, B., and Levy, M. N.: A humoral reticuloendothelial-depressing substance in shock. Amer. J. Physiol., 203:409, 1962.
9. Blattberg, B., and Levy, M. N.: Mechanism of depression of reticuloendothelial system in shock. Amer. J. Physiol., 203:111, 1962.
10. Zweifach, B. W., Benacerraf, B., and Thomas, L.: The relationship between the vascular manifestations of shock produced by exotoxin, trauma and hemorrhage. J. Exper. Med., 106:403, 1957.
11. Zweifach, B. W., and Benacerraf, B.: Effect of hemorrhagic shock on the phagocytic function of Kupffer cells. Circulation Res., 6:83, 1958.



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Brief and to the Point

GOES TO AFRICA—Joseph W. Christie, M.D., has left Northport to go to Northern Rhodesia to found a leprosarium which he hopes will eventually serve much of Africa. Doctor Christie left an established practice at Pontiac in 1951 to settle at Northport and he founded a hospital there. Today, there is a 32-bed, half-million-dollar Leelanau Memorial Hospital as his legacy.

LECTURE TOUR—Speeches in New York, San Francisco, Honolulu, Cairo, and London took Bruce Proctor, M.D., Pontiac, around the world recently. He spoke to ophthalmologists and/or otolaryngologists at four meetings and then the Royal Society of Medicine at London.

RESUMES PRACTICE—David A. Bowman, M.D., of Bay City, former MSMS Councilor for that district, has returned to his practice after six months of postgraduate work in psychosomatic services at Menninger School of Psychiatry at Topeka.

AUTOGRAPH PARTY—An autograph party for Hazen L. Miller, M.D., Royal Oak, was held recently at Birmingham to help mark the publication by Doctor Miller of his book, "The Old Au Sable." Doctor Miller has explained that "I like the people of the Au Sable and had been collecting odds and ends for a book. I decided to tie them together—the book is something that just grew."

TOURED AFRICA—Charles Wright, M.D., Detroit, made a six-week tour of Liberia, Nigeria and Sierra Leona to study ways that physicians and dentists can assist the health programs there. Doctor Wright has been active in the African Medical Education Fund which has provided assistance to African medical students in the USA.

CONTINUES RESEARCH—Walter H. Seegers, M.D., Grosse Pointe, has received a grant from the National Institutes of Health to Wayne State University to continue his blood research program.

HONORED—J. W. O'Neill, M.D., White Cloud, recently was honored by employees, former employees and members of the Lake, Newaygo and Oceana Health Committee of the three Boards of Supervisors. The event paid tribute to Doctor O'Neill for his 20 years of service as director of the district health department.

RETIRES—J. J. Austin, M.D., general practitioner at Tawas City for 29 years, recently retired. Long active in civic affairs, Doctor Austin is a former president of the Tawas City Board of Education.



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Doctor and Mrs. Austin plan to travel this winter and return to the Tawas area in the spring.

FOR FUN—A group of doctors from the William Beaumont Hospital, Royal Oak, formed a band to entertain at the hospital's annual employee Christmas party. The group included William Bauer, M.D., drums; Bruce Gerletti, M.D., trombone; Bruce Bauer, M.D., clarinet; Elmer Mueller, M.D., accordion; Frederick Bryant, M.D., trumpet; Frederick Latimer, M.D., bass; Thomas Grekin, M.D., xylophone, and Adolph Bruni, M.D., electric guitar.

AHA LEADERS—Among the leaders in the American Hospital Association are the following MSMS members—Robin C. Buerki, M.D., Detroit, chairman, committee on international relations; Edwin L. Harmon, M.D., Detroit, chairman, committee on homes and ambulatory care; James T. Howell, M.D., Detroit, vice chairman, council on professional practice; Roger B. Nelson, M.D., Ann Arbor, AHA representative to joint committee with American Dietetic Association.

SPEAKERS—The December meeting of the associate and active medical staff of the Haven Hospital featured a session on "Erotic Transference" with Drs. Jack F. Ensroth, and George S. Evseeff as primary discussants.

COMES TO STATE—Henry L. Vogl, M.D., formerly staff physician at the St. Paul, Minnesota, Veterans Administration area medical office, has been appointed director of the Iron Mountain Veterans Administration Hospital. He succeeded Reed L. Clegg, M.D., who was transferred as director to the Newington, Connecticut, VA Hospital. Doctor Vogl received his M.D. degree from Marquette University in 1930.

ELEVATED—George D. Beamer, M.D., Dearborn, recently was elevated from associate membership to full membership in the American Rhinologic Society.

SPEAKER—Herbert Raskin, M.D., Detroit, discussed "The Traumatic Neurosis" or "The Pressure Principle" at the recent meeting of the Detroit Psychoanalytic Society and Institute. The paper was then discussed by Paul H. Feldman, M.D., and William Purves, M.D., both officers of the Society.

Medical Meetings USA

APRIL

American Academy of General Practice, Convention Hall. Atlantic City, N. J., April 11-16. Exec. Dir.: Mac F. Cahal, JD, Volker Boulevard at Brookside, Kansas City 12.

American Association of Pathologists and Bacteriologists, Drake Hotel, Chicago, April 3-5. Sec.-Treas.: John R. Carter, M.D., University of Kansas Medical Center, Kansas City 3.

American Association of Railway Surgeons, Drake Hotel, Chicago, April 8-10. Exec. Sec.: Carl Y. Werelius, M.D., 5800 Stony Island, Chicago 37.

American College of Physicians, Chalfonte-Hadden Hall, Atlantic City, N. J., April 6-10. Exec. Dir.: Edward C. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia 4.

American Society of Internal Medicine, Atlantic City, N. J., April 3-5. Exec. Dir.: Albert V. Whitehall, 3410 Geary Blvd., San Francisco 18.

Industrial Medical Association, Pittsburgh-Hilton Hotel, Pittsburgh, April 13-16. Managing Dir.: Clark D. Bridges, 55 E. Washington, Chicago 2.

Say you saw it in the Journal of the Michigan State Medical Society

Ohio State Medical Association, Columbus Plaza Hotel, Columbus, April 26-30. Exec. Sec.: Charles S. Nelson, 79 E. State St., Room 1005, Columbus 15.

MAY

Aerospace Medical Association, Americana Hotel, Bal Harbour, Fla., May 11-14. Sec.: William J. Hennard, M.D., Washington National Airport, Washington 1, D. C.

American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Fla., May 17-22. Exec. Dir.: Donald F. Richardson, 79 W Monroe, Chicago 3.

American Gynecological Society, Homestead Hotel, Hot Springs, Va., May 25-27. Sec.: C. J. Lund, M.D., 260 Crittendon Blvd., Rochester 20, N. Y.

American Ophthalmological Society, Homestead Hotel, Hot Springs, Va., May 28-30. Sec.: Joseph A. C. Wadsworth, M.D., 108 E. 68th St., New York 21.

American Proctologic Society, Bellevue-Stratford Hotel, Philadelphia, May 10-14. Sec.: Norman D. Nigro, M.D., 320 W. Lafayette, Detroit 26.

American Urological Association, Penn-Sheraton Hotel, Pittsburgh, May 11-14. Exec. Sec.: William P. Didusch, 1120 N. Charles St., Baltimore 1.

Illinois State Medical Society, Sherman House Chicago, May 17-21. Convention Mgr.: A. G. Boerck, 360 N. Michigan, Chicago 1.

JUNE

American College of Chest Physicians, Jack Tar Hotel, San Francisco, June 18-22. Sec.: Edward B. Allen, M.D., 10 Columbus Circle, New York 19.

American Geriatrics Society, Sir Francis Drake Hotel, San Francisco, June 19-20. Sec.: Edward B. Allen, M.D., 10 Columbus Circle, New York 19.

American Medical Association, Fairmont and Mark Hopkins hotels and Civic Auditorium, San Francisco, June 21-25. Exec. Vice-Pres.: F. J. L. Blasingame, M.D., 535 N. Dearborn, Chicago 60610.

JULY

American Diabetes Association, Toronto, July 19-23. Info.: J. Richard Connelly, 1 E. 45th St., New York 17.

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The Doctor's Library

Books received by The Journal of the Michigan State Medical Society *are acknowledged in this column. Selections will be made for more extensive review in the interest of readers as space permits.*

INTRODUCTION TO PSYCHIATRY. By Kurt Kolle. New York: Philosophical Library, 1963. Price, $3.00.

FUNDAMENTALS OF NEUROLOGY. By Ernest Gardner, M.D., Professor of Anatomy, Wayne State University College of Medicine. Fourth Edition. Illustrated. Philadelphia and London: W. B. Saunders Company, 1963. Price, $6.25.

MOVING INTO MANHOOD. By W. W. Bauer, B.S., M.D., LL.D., Director of Health Education, Emeritus, American Medical Association. Foreword by Morris Fishbein, M.D. Garden City, New York: Doubleday and Company, Inc., 1963. Price, $2.95.

AN INTRODUCTION TO THE SCIENCE OF HUMAN BEHAVIOR. By John I. Nurnberger, M.D., Professor and Chairman, Department of Psychiatry and Director, Institute of Psychiatric Research, Indiana University Medical Center; C. B. Ferster, Ph.D., Executive Director, Institute for Behavioral Research and Research Associate Professor, University of Maryland; John Paul Brady, M.D. Assistant Professor, Department of Psychiatry, Research Psychiatrist, Institute of Psychiatric Research, Indiana University Medical Center. Foreword by David Mck. Rioch. New York: Appleton-Century-Crofts Division of Meredith Publishing Company, 1963. (No price given)

RADIOLOGICAL HEALTH PROGRAMS

(Continued from Page 138)

Health. The program was carried out by means of a survey packet mailed to every dentist in the state. Each packet included the pamphlet, "Radiation Protection for Dentist and Patient," a sheet illustrating recommended beam sizes, and an 8" x 10" film having an aluminum step edge attached. Each dentist was asked to expose the film with his x-ray machine and return it to the state health department.

As the exposed films were received they were forwarded to the Public Health Service's Radiological Health Laboratory where each film was processed under careful controls. On the basis of the developed film a number of safety factors were determined. If the need was indicated, a filter or a collimator (or both) was sent to the dentist with instructions for placing it in the x-ray machine.

As a result of the program, filters and collimators were added to 1,100 x-ray machines and filtration alone to another 535. The estimated reduction in total facial-skin-air dose as a result of the program was one-and-one-half million roentgens. The reduction in calculated area of facial primary beam exposure was over 7,000,000 square inches.

These estimates are based on the assumption that all machines were actually corrected. Future plans call for follow-up to determine the exact amount of voluntary compliance with the recommendations made.

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1—Date of filing: **October 30, 1963.** 2—Title of Publication, **Journal of the Michigan State Medical Society.** 3—Frequency of issue, **Monthly.** 4—Location of known office of publication, **2642 University Avenue, St. Paul (Ramsey County), Minnesota 55114.** 5—Location of the headquarters or general business offices of the publishers, **120 West Saginaw Street, East Lansing, Michigan (Ingham County).** 6—Names and addresses of Publisher, Editor, and Managing Editor, **Publisher, Michigan State Medical Society, 120 West Saginaw St., East Lansing, Mich.; Editor, Chas. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan; Managing Editor, Herbert A. Auer, 120 West Saginaw Street, East Lansing, Michigan.**
7—Owner—

Michigan State Medical Society, 120 West Saginaw St., East Lansing, Mich.
I certify that the statements made by me above are correct and complete. Herbert A. Auer by W. T. Coulter.

IN MEMORIAM

B. W. CULVER, M.D., 82, Coldwater area physician for many years, died November 29, 1963.

A 1907 graduate of the University of Michigan Medical School, Doctor Culver had practiced in Coldwater from the time of his graduation until his retirement about five years ago.

He was a Life Member of the Michigan State Medical Society.

CARL H. FRYE, M.D., 66, Ann Arbor general practitioner, died November 19, 1963.

A graduate of the University of Michigan Medical School in 1925, Doctor Frye interned in Pittsburgh, Pa., and practiced in Milan from 1927 until he came to Ann Arbor in 1931.

A member of the staff of St. Joseph Mercy Hospital, Doctor Frye was active in the Washtenaw County Medical Society and the American Academy of General Practice.

LOUIS W. GERSTNER, M.D., 69, Kalamazoo physician since 1927, died November 20, 1963.

A 1926 graduate of the University of Michigan Medical School, Doctor Gerstner served as Kalamazoo city physician until he began his private practice in 1928.

He was a Past President of the Kalamazoo Academy of Medicine and a member of the Kalamazoo Medical Journal Club.

WILLIAM G. HOEBEKE, M.D., 74, retired Kalamazoo physician, died November 19, 1963.

Doctor Hoebeke practiced medicine in Kalamazoo for 40 years prior to his retirement in 1959. He was a graduate of the University of Pennsylvania Medical School in 1916. Following army service in World War I, he began his general practice in Kalamazoo in 1919, later specializing in obstetrics and gynecology.

He was a Life Member of the Michigan State Medical Society, a Fellow of the American College of Surgeons and Past President of the Kalamazoo Academy of Medicine.

MARTIN H. HOFFMAN, M.D., 65, former medical director of St. Joseph's Retreat, Detroit, died December 18, 1963.

A psychiatrist, Doctor Hoffman was with St. Joseph's Retreat from 1945 until last year. He was director of the psychiatric division at Wayne County General Hospital from 1935 until 1945, and also head of the Wayne County Psychopathic Parole Clinic during that time.

A 1922 graduate of the University of Iowa Medical College, he came to Detroit as an intern at Harper Hospital.

Doctor Hoffman was cofounder and past president of the Guild of Catholic Psychiatrists, past president of the Central Neurosychiatric Association and of the Michigan Society of Neurology and Psychiatry. He was the incorporator of the Michigan Society of Mental Hygiene and a charter member of the Academy of Religion and Mental Health.

J. A. KAUPPINEN, M.D., 52, Southfield physician for 20 years, died December 21, 1963.

A native of Finland who came to the U. S. as an infant, Doctor Kauppinen was graduated from Harvard Medical School.

He was on the staff of Mt. Carmel Mercy Hospital and a member of the American College of Physicians.

WILLIAM B. McWILLIAMS, M.D., 74, St. Johns, died November 22, 1963.

Doctor McWilliams was graduated from Northwestern University Medical School and served as a Navy medical officer in World War I before coming to Maple Rapids in 1919. He practiced there until his retirement in 1962, when he moved to St. Johns.

He was a Life Member of the Michigan State Medical Society and was on the staff of Clinton Memorial Hospital.

JOHN D. MONROE, M.D., 71, Pontiac, director of the Oakland County Health Department since 1927, died December 2, 1963.

Doctor Monroe was graduated in 1917 from Wayne State University College of Medicine and was in general practice in Pontiac from 1920 to 1926, prior to becoming director of the Oakland County Health Department. He also served as health director for the city of Pontiac. He was elected president of the Michigan Public Health Association early in 1963 and was a past president of the Oakland County Medical Society. He was also a medical examiner for Oakland County.

He was a Life Member of the Michigan State Medical Society.

EMMA L. W. SHEPPARD, M.D., 86, one of the first women to practice medicine in Detroit, died December 31, 1963.

Doctor Sheppard was graduated from the Detroit College of Homeopathic Medicine and Surgery in 1908. She practiced in Detroit for more than 50 years and was on the staff of Grace Hospital, specializing in obstetrics.

She was a Retired Member of the Michigan State Medical Society.

WILLIAM WACEK, M.D., 65, Ironwood general practitioner, died December 1, 1963.

Doctor Wacek was graduated in 1925 from Creighton University School of Medicine at Omaha, Nebraska.

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SORRY, Psychiatric Residencies Filled. We cannot accept additional applications for processing for July, 1964. However, we welcome applications for July, 1965. Fully approved program of balanced didactic and clinical training. In Michigan's Vacationland. Five-year career plan: $8,519, $9,855, $11,525, $14,908 and $15,722. Dr. Curtis W. Page, Director of Training, Traverse City State Hospital, Traverse City, Michigan.

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AMA—Fallacies and Facts

For more than a decade a number of fallacies about the American Medical Association have appeared in the press, in speeches, or have been aired on radio and television. Most of these false statements have been written or spoken because of misunderstanding, misinformation, or lack of knowledge about the AMA.

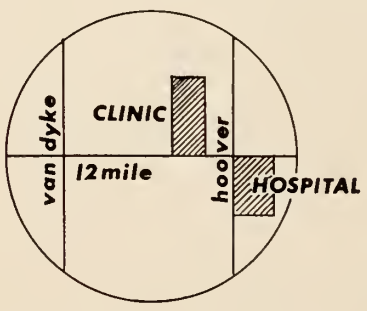
Here is one of the most persistent fallacies about the AMA—and the facts:

Fallacy.—AMA exercises "strong sanctions against individual doctors who speak up" against AMA policy.

Fact.—The charge is generated out of politics, usually in connection with discussion of medical care for the aged which, all too sadly, has become a political issue. Thus, the inference is drawn that the AMA punishes any member who dares expound a political view opposed to a course of action adopted by a majority of AMA members. "Strong sanctions" implies that the AMA disciplines such contrariness by squeezing the offender out of hospitals or by some similar interference with his professional freedom.

The charge is singularly ridiculous on its face. Doctors for the most part are strong individualists keenly attuned to the blessings of American freedoms, including the freedom of speech. They have demonstrated many times over their dedication to preserving all freedoms.

Devotion to individual liberty against government collectivism is the very core of their opposition to socialized medicine. And yet, the charge suggests that physicians, through the AMA, impose a tyranny of the majority over their fellow men. It's patently absurd. The AMA, in fact, possesses no such disciplinary power. It can't even punish a member for unethical conduct by anything more severe than cancellation of membership. The simple truth is that physicians who disagree with AMA policy, both scientific and political, do speak up without fear of reprisal.



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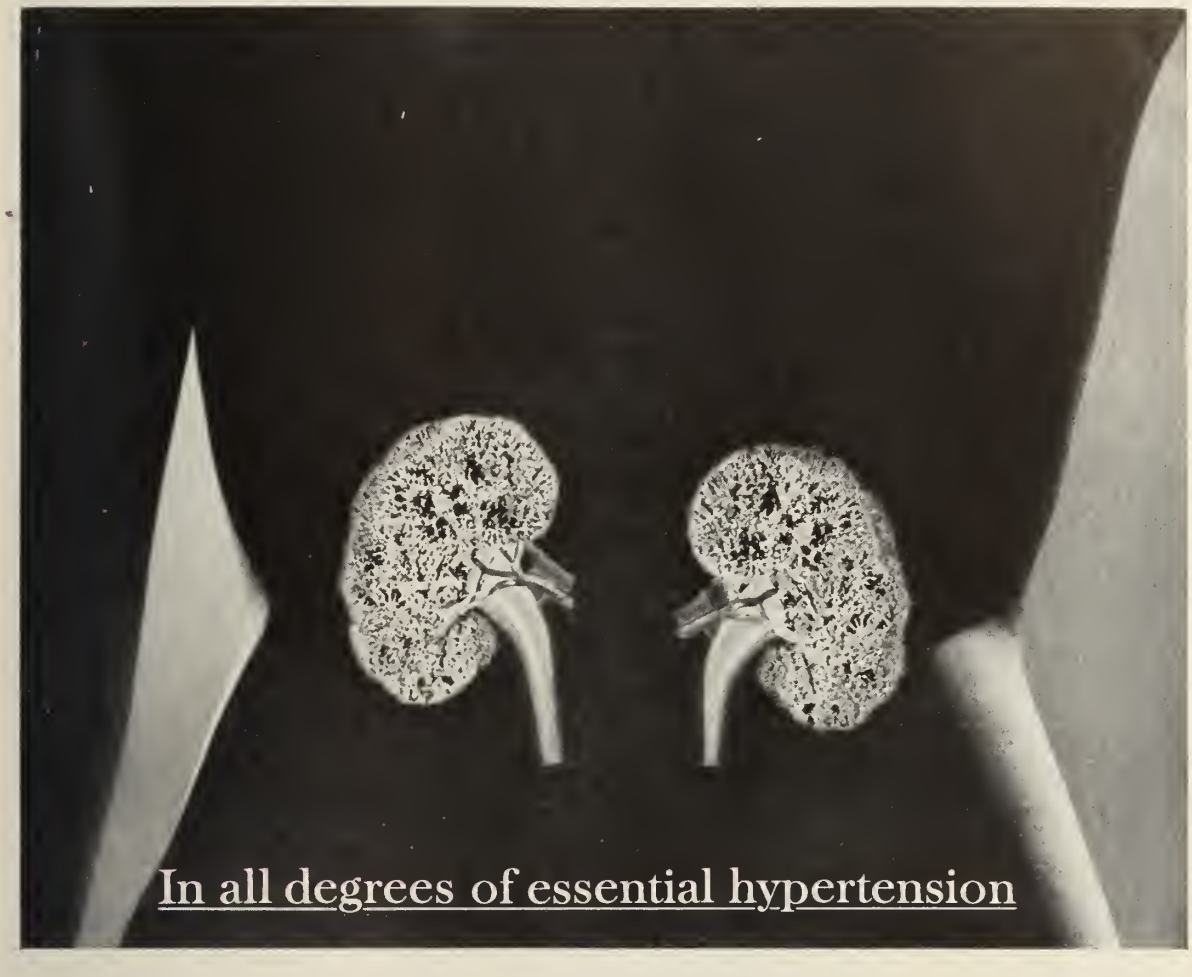
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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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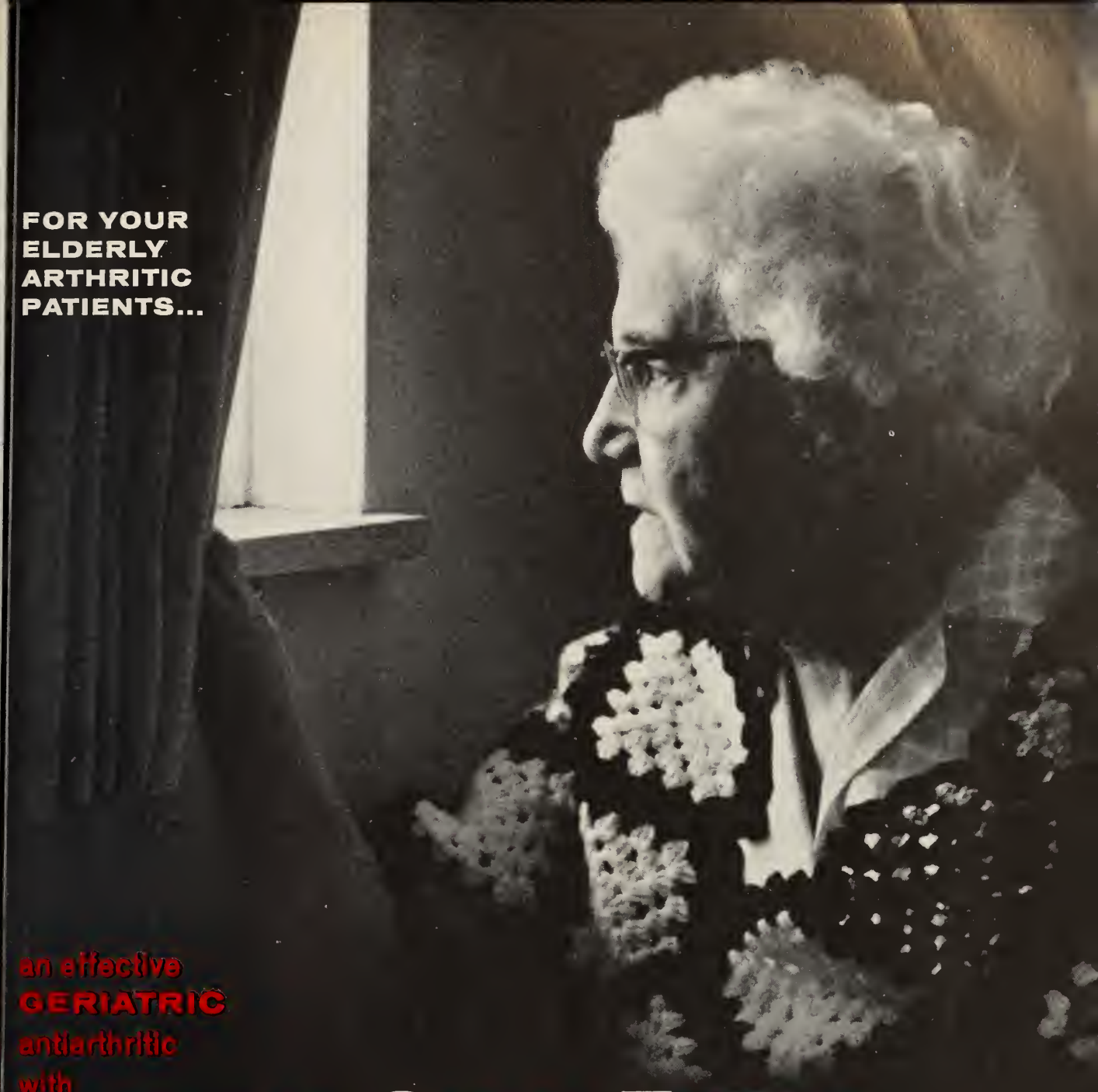
DELEGATES TO A. M. A.

Delegates

	Term Expires
C. I. Owen, M.D., Detroit	1964
G. W. Slagle, M.D., Battle Creek	1964
D. N. Sweeny, Jr., M.D., Detroit	1964
J. R. Heidenreich, M.D., Daggett	1965
W. A. Hyland, M.D., *Chairman*, Grand Rapids	1965
O. J. Johnson, M.D., Lansing	1965
L. R. Leader, M.D., Birmingham	1965

Alternates

	Term Expires
R. E. Rice, M.D., Greenville	1964
A. Hazen Price, M.D., Detroit	1964
E. E. Martmer, M.D., Grosse Pte	1964
Sidney Adler, M.D., Detroit	1965
G. B. Saltonstall, M.D., Charlevoix	1965
B. M. Harris, M.D., Ypsilanti	1965
L. A. Drolett, M.D., Lansing	1965



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President's Page

COMMENTS ON TWO 1963 RESOLUTIONS



Orlan J. Johnson M.D.

President
Michigan State Medical Society

The 1963 House of Delegates of MSMS passed two resolutions dealing with the conduct and activity of physicians practicing in Michigan.

One directed The Council to study the establishment of a disciplinary board with legal status. Such a board is functioning in the State of Washington. It was established by legislative enactment and hence has the powers designated. It can investigate and hold hearings on matters not customarily given to a licensing board. It may delve into conduct by physicians which are not necessarily illegal but that may be unethical or are in poor professional taste. This board's activities have been tested and upheld by the Courts of Washington. No conclusion has been reached by the MSMS. This is a major matter that deserves serious consideration in determining which way to move.

The fact that the House of Delegates passed such a resolution would indicate there should be a change in organized medicine's method of handling conduct within our ranks or ask for some outside legal body to do so.

The Michigan Board of Registration has only certain restricted powers which they have not been able to exercise fully because of financial limitation. It was hoped and expected that the State Board would benefit from the monies received from physician yearly registration but such is not the case. Even if the funds were available, their field of power would not be as inclusive as a disciplinary board.

If the question of the House of Delegates was how shall the conduct of physicians be controlled and apparently felt it should—the question is still being studied.

The second resolution directed The Council to determine if a program on utilization on a state level should be developed. Preliminary consideration reveals that this is an extremely complex problem that is not easily answered either as to magnitude or method handling. It does appear that more use should be made of the established procedures and committees in hospitals and local medical societies. If it should be that these steps do not produce the desired results, a new more stringent system will be required.

It appears that the two resolutions of the House are related.

"Write to Congressmen" Stressed at MSMS Seminar



Strong appeals to "write your congressmen" were leveled at county society leaders by MSMS and AMA speakers at the annual MSMS "County Secretaries-Public Relations Seminar" in Lansing, February 27.

The importance of letters to stress the values of the Kerr-Mills law and to oppose the King-Anderson scheme was hit home in the address by F. J. L. Blasingame, M.D., executive vice-president of the AMA.

Orlen J. Johnson, M.D., MSMS president, opened the one-day seminar, which drew 200 county society officers and chairmen. The morning program dealt primarily with internal matters and the afternoon put the spotlight on legislation and "Operation Hometown." An "Operation Hometown" panel was led by Edgar E. Martmer, M.D., Chairman of the MSMS Council's County Society Committee.

* * *

TWO OTHER AMA leaders appeared on the program—Robert B. Throckmorton, LLM, general counsel, talked about "Keeping Medicine's House in Order," and Rev. Dr. Paul B. McCleave, director of the Department of Medicine and Religion, explained this new activity.

The Annual Awards Luncheon at noon featured the presentation of MSMS citations to leaders in education, legislation, communications and civic service. The MSMS Council, at its January meeting, voted the following citations:

* * *

"DISTINGUISHED HEALTH SERVICE AWARDS" for their contributions to the health of Michigan citizens to Frederick A. Coller, M.D., Ann Arbor; A. C. Furstenberg, M.D., Ann Arbor; and William J. Stapleton, Jr., M.D., Detroit.

"Outstanding Health Service Awards" for special accomplishments and contributions to Mrs. Irene M. Auberlin, Detroit, president, World Medical Relief; Gordon H. Scott, Ph.D., former Dean, Wayne State University College of Medicine and now WSU vice president for medical college development; Robert J. Gillespie, St. Joseph, president, American Pharmaceutical Association; Alvin M. Bentley, Owosso, Michigan chairman, Project Hope; Harry J. Loynd, Detroit, president, Parke-Davis Company and two veteran Michigan Legislators, State Senator Frank D. Beadle, St. Clair, and Representative Edson V. Root, Jr., Bangor.

Six foundations were cited: Dow Foundation, Midland; Kalamazoo Foundation, Kalamazoo; Kellogg Foundation, Battle Creek; Kresge

Foundation, Detroit; MacGregor Foundation, Detroit; and Mott Foundation, Flint.

* * *

CITED IN THE communications field were: *Bay City Times, Benton Harbor News Palladium, Flint Journal, St. Joseph Herald-Press,* Editor Jean Worth of Escanaba *Daily Press,* Managing Editor Frank Angelo of the *Detroit Free Press,* Editor Martin Hayden of the *Detroit News,* WILS of Lansing, WDET of Detroit, WJR of Detroit, WOOD-TV of Grand Rapids, and WJIM-TV of Lansing.

Six Michigan doctors who serve as presidents of national health organizations were cited: Reed O. Dingman, M.D., Ann Arbor, American Society of Plastic and Reconstructive Surgery; A. E. Heustis, M.D., Lansing, Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities; R. L. Mainwaring, M.D., Dearborn, American Association of Blood Banks; Kenneth P. Mathews, M.D., Ann Arbor, American Academy of Allergists; E. C. Swanson, M.D., Vassar, Federation of State Medical Boards of the United States; Myron E. Wegman, M.D., Ann Arbor, Association of Schools of Public Health; James Leroy Wilson, M.D., Ann Arbor, American Pediatric Society.

Wm. A. Scott, M.D., Dies: Fourth District Councilor

Wm. A. Scott, M.D., MSMS Councilor for the Fourth District, died unexpectedly in his home in Kalamazoo, February 23. Doctor Scott was elected a Councilor in 1959 to fill the unexpired term of Ralph W. Shook, M.D., Kalamazoo. He was elected to a full three-year term in 1961 and was chosen as chairman of The Council's Publication Committee, also in 1961. Doctor Scott, 59 years old, was graduated from the University of Michigan Medical School in 1930 and established practice as a psychiatrist in Kalamazoo in 1937. He had been head of the psychiatric unit at Kalamazoo Borgess Hospital since 1957.



WM. A. SCOTT, M.D.

He was a member of Governor Romney's Mental Health Advisory Council, and was active in several state and national psychiatric organizations.

His private practice was interrupted by almost five years of service as an Army psychiatrist during World War II.

Adopts New MSMS Policy On Oral Polio Vaccine

A new policy statement was adopted by The MSMS Council at its January meeting regarding the use of Oral Polio Vaccine.

The Council adopted a report of its Ad Hoc Committee on Oral Polio Vaccine—Robert J. Mason, M.D., Chairman, E. E. Martmer, M.D., F. D. Richards, M.D., and W. J. Zimmerman, M.D. The Committee reported that oral vaccine is now being used by several states and that there has been a change in the attitude nationally as to the use of oral polio vaccine.

Following is the new Council statement:

"Since both killed and oral type of poliomyelitis vaccine are now licensed and available to physicians, the decision as to which type of vaccine an individual physician would use in his office rests with that physician himself.

"In the presence of an outbreak of a type specific epidemic of polio the combined medical forces of the local medical society and the local health department should act as a team in protecting all members of the community with oral polio vaccine.

"If a community, as a public relations measure, desires to conduct an elective mass polio immunization, the guidelines previously established should be followed. In general this includes maintenance of individual records for each person who receives the vaccine, the securing of an adequate supply of vaccine to protect the community and a definite program of follow-up to protect all new members arriving in the community after the initial mass immunizing program. It is extremely important that the community level of protection against smallpox, diphtheria, tetanus and whooping cough, as well as polio, be vigorously maintained."

ACOG Lauds Projects of Maternal Health Committee

The MSMS Council, at its last meeting, learned that the American College of Obstetricians and Gynecologists is interested in the MSMS Maternal Health Committee desk reference cards.

The chairman of the MSMS committee, William W. Jack, M.D., of Grand Rapids, shared a letter from Harold A. Ott, M.D., Royal Oak, a member of the MSMS Committee. Doctor Ott wrote, "In my report to the Executive Board of the ACOG as chairman of the Committee on Obstetric Analgesia and Anesthesia, I included the MSMS Desk Reference Card No. 1, "Spinal Anesthesia (Saddle Block) in Obstetrics," to illustrate what your committee is doing in this field. Robert Kimbrough, M.D., ACOG medical director, phoned me by long distance after reading my report to ask for an additional 20 cards so that each member of his Executive Board would have one. He was very impressed. I sent the additional cards as well as Card No. 2 on "Septic Shock." ACOG is very enthusiastic about the MSMS activities."

(Turn to Page 172)



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HIGHLIGHTS

Annual Meeting of The Council January 22-23, 1964, East Lansing

Following is a brief review of some of the actions taken by The Council at its Annual Meeting:

The Council agreed to meet in joint session with the Board of Trustees of Michigan Medical Service for the purpose of exchanging information and discussing mutual problems. The meeting is planned before the end of March.

Expressed its appreciation to Retired Councilor W. W. Babcock, M.D., for his long and exemplary service to county and state medical society and the AMA.

Expressed appreciation to J. W. Rice, M.D., for his fine work for MSMS and as Vice-Speaker of the House of Delegates.

Accepted report of Building Advisor Kenneth H. Johnson, M.D., Lansing, who reviewed maintenance of the headquarters and reported that over 100 meetings were held in the building during 1963.

Authorized MSMS representatives to attend the National Conference on Rural Health, March 6-7, Columbus, Ohio, and the Tenth Annual Conference of State Mental Health Representatives, February 14-15, 1964, Chicago.

Approved the appointment of Brooker L. Masters, M.D., Fremont, to the Liaison Committee with Michigan Society of Osteopathic Physicians and Surgeons.

Referred questions re University of Michigan Hospital Desk Reference Guide to the MSMS Education Liaison Committee.

Approved the appointment of MSMS Delegate R. W. Teed, M.D., Ann Arbor, and Alternate Delegate K. W. Toothaker, M.D., Lansing, to the Michigan Health Council.

* * *

REFERRED TO THE COUNTY SOCIETIES Committee of The Council the matter of developing suggestions for a new definition of public health for transmission to the Board of Trustees of the American Medical Association. The AMA House of Delegates authorized such a redefinition of the AMA position on public health be prepared.

Approved appointment of Stuart M. Gould, M.D., Ann Arbor, and E. H. Rodda, M.D., Bay City to the Legal Affairs Committee; and approved appointment of John Weller, M.D., Ann Arbor, to the Maternal Health Committee.

Instructed that the AMA action and position regarding the inclusion of medical benefits under a hospital service contract be transmitted to the Michigan Hospital Association Board of Trustees. This action resulted from review of a letter and resolution adopted by the Michigan Hospital Association Board of Trustees recommending that Blue Cross, as the agent of the voluntary hospital, undertake to transfer all hospital service benefits from the Blue Shield contract to Blue Cross subscriber contracts.

Accepted an invitation from the Michigan Hospital Association for MSMS to appoint a representative to the Michigan Hospital Association Committee on Pharmacy.

* * *

RECEIVED A REPORT OF PROGRESS on AMA-ERF and report that the funds collected from the MSMS 1963 special assessment for AMA-ERF would be distributed to the deans of the two medical schools at the Awards Luncheon of the Annual County Secretaries Public Relations Seminar February 27 in Lansing.

Reconsidered its action of November, 1963, which referred the matter of liaison with the Michigan Crippled Children Commission to the Liaison Committee with the State Executive Office, and in lieu thereof appointed a special committee of The Council to serve as the Liaison Committee with Michigan Crippled Children Commission, with representation on a geographic basis as requested by the House of Delegates.

Received an annual report from Michigan Medical Service, President Sidney Adler, M.D.

Authorized B. M. Harris, M.D., Ypsilanti, to meet with Board of Trustees, Peoples Community Hospital Authority, if requested.

* * *

EXPRESSED THANKS TO MSMS Delegation to the American Medical Association for its excellent work, with special commendation to Chairman Wm. A. Hyland, M.D., for his excellent report.

Received report of Legal Counsel, which reviewed interpretation of bylaws, suspension of members by component society, use of case histories for teaching purposes, staff selection by hospital.

Received correspondence from W. W. Jack, M.D., Chairman of MSMS Maternal Health Committee, conveying the enthusiastic interest of the American College of Obstetricians and Gynecologists in the activities of the Maternal Health Committee and its Maternal Health Desk Card sent to MSMS members.

Approved a recommendation that the 1966 Annual

(Continued from Page 174)



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Highlights of the Annual Meeting of The Council

(Continued on Page 172)

Session be held in Grand Rapids and the 1967 Annual Session be held in Detroit.

Approved a staff recommendation that two offices on the second floor of MSMS headquarters be converted to committee rooms.

Approved a recommendation that a special meeting of The Council with invited guests be held on March 9 in Detroit to discuss future relationships between medicine and osteopathy.

Reconsidered and reaffirmed, with minor amendment, the November action of The Council in relation to chemical tests for intoxication.

* * *

ADOPTED POLICY WITH RESPECT to use of killed and oral type of poliomyelitis vaccine, and instructed that this policy be made available to all component societies.

Approved the Annual Report of the Treasurer.

Adopted 1964 budget estimates.

Authorized MSMS staff to survey other states and study methods of providing financial assistance for indigent physicians.

Authorized an expenditure not to exceed $500 as the MSMS share of the cost of a statewide iodized salt educational campaign as recommended by the MSMS Iodized Salt Committee.

Approved the Editor's Report and 1964 Journal budget.

Authorized an MSMS Journal readership survey to be undertaken and that a survey plan be presented by the Managing Editor to the Publication Committee for approval.

Authorized the Managing Editor to develop and present one or more possible new formats for The Journal of MSMS.

* * *

APPROVED THE ANNUAL REPORT of the Secretary.

Authorized the President to sign Medicare contracts as certified by the Secretary, and that a committee be authorized to study revisions in the Medicare contract which might be incorporated in the 1965 contract.

Received an annual report from Michigan Hospital Service, President Wm. S. McNary, and received assurances from Mr. McNary that MSMS representatives would be invited to be present at a future meeting of the Board of Trustees of Michigan Hospital Service when that Board discusses the Michigan Hospital Association resolution requesting transfer of benefits from Blue Shield contracts to Blue Cross contracts.

D. Bruce Wiley, M.D., was re-elected as Secretary of MSMS.

Wm. A. Hyland, M.D., was re-elected as Treasurer of MSMS.

C. J. Tupper, M.D., was re-elected as Scientific Editor of The Journal, MSMS.

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Michigan Medical Meetings

April

Western Michigan Trauma, April 22, Muskegon Country Club.

May

Michigan Chapter, American Medical Writers' Association, May 13, Michigan Union Club, Ann Arbor.

MSMS Maternal and Perinatal Mortality Workshop, May 14-15, Gull Lake Conference Center, Battle Creek.

Wayne State University Clinic Day and Alumni Reunion, May 20, Detroit.

June

Upper Peninsula Medical Society Annual Meeting, June 12-13, Houghton.

Michigan Hospital Association, 45th Annual Convention, June 14-16, Grand Hotel, Mackinac Island.

July

Coller-Penberthy Clinic, July 30-31, Traverse City.

September

Michigan State Medical Society Annual Session, September 20-26, Sheraton Cadillac Hotel, Detroit.



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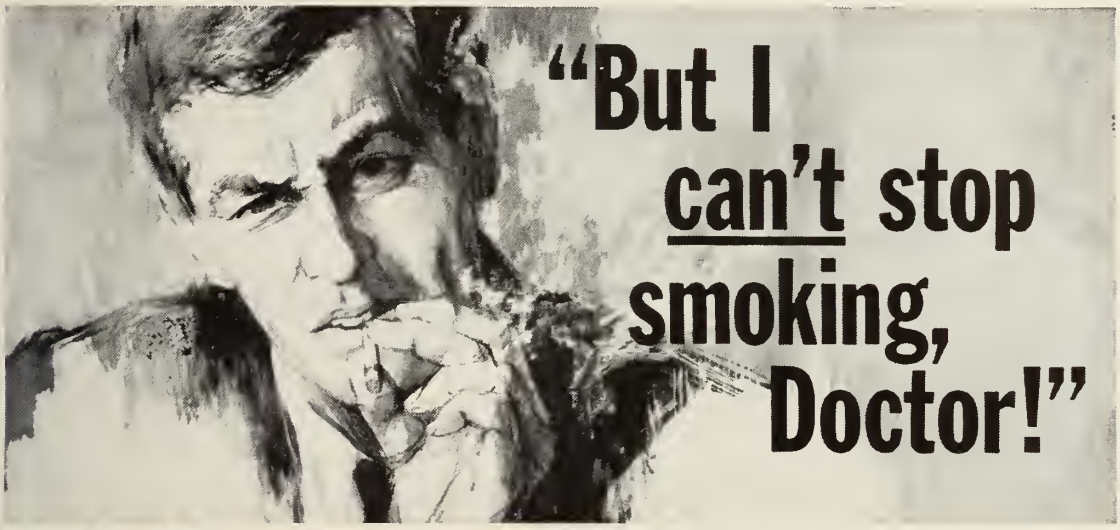
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1st week: 1 pastille every 1 to 2 hours for a maximum of 12 pastilles daily. *2nd week:* 1 pastille every 3 hours. *3rd week:* 1 pastille every 4 hours. *4th week:* 1 pastille every 4 to 6 hours. *Thereafter* 1 pastille may be taken at infrequent intervals whenever necessary. In some instances there may at first be a slight astringent burr of the tongue and throat. This will usually disappear as treatment with NIKOBAN Pastilles progresses and is no cause for concern.

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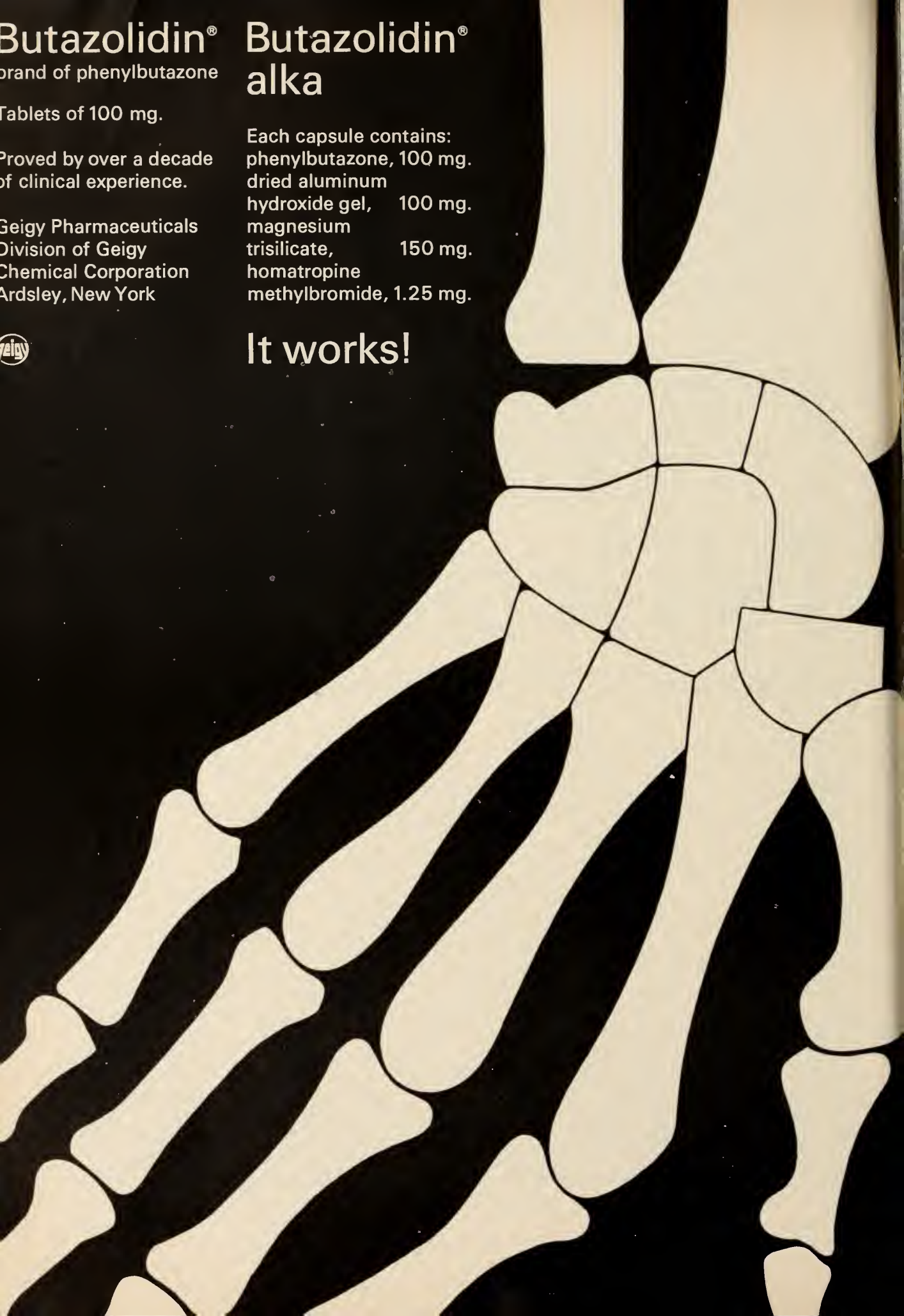
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Doctors Urged to Be Active Participants in Politics

At a recent joint meeting of the Saginaw County Medical Society and its Auxiliary, Durward C. Hall, M.D., Congressman from Missouri, urged the doctors "to participate in politics, to support responsible legislation and to work as hard to defeat irresponsible legislation."

In talking about "Fedicare" he pointed out "Your county medical society is one means of providing eternal vigilance against this threat of freedom." He added that the, "County medical society can be only as effective as the individual physician wants to make it."

Congressman Hall saluted Saginaw's Congressman James Harvey, who was a guest at the banquet. He called Congressman Harvey a "statesman" and added, "The most challenging and stimulating thing there is in the United States is to serve in Congress with men like your Jim Harvey. My hat is off to him for the job he is doing."

State legislators and MSMS officials also were guests at the excellent program that drew 250 doctors and their wives to the Bancroft Hotel.



Washtenaw Issues Three Honorary Memberships

Three emeritus members of The University of Michigan Medical School faculty have been given honorary membership in the Washtenaw County Medical Society.

Honored were Elizabeth C. Crosby, Ph.D., professor-emeritus of anatomy and consultant in neurosurgery; Reuben L. Kahn, Sc.D., professor-emeritus of serology; and Bradley M. Patten, Ph.D., professor-emeritus of anatomy.

It marked the first time in recent years that the Society has conferred honorary memberships.

Self Help Courses Offered

During 1963, 214 persons were graduated from Medical Self Help Courses in Kalamazoo. The Catastrophe Medical Service Committee of the Kalamazoo Academy of Medicine coordinated the course work.

The MSMS House of Delegates has urged component county medi-

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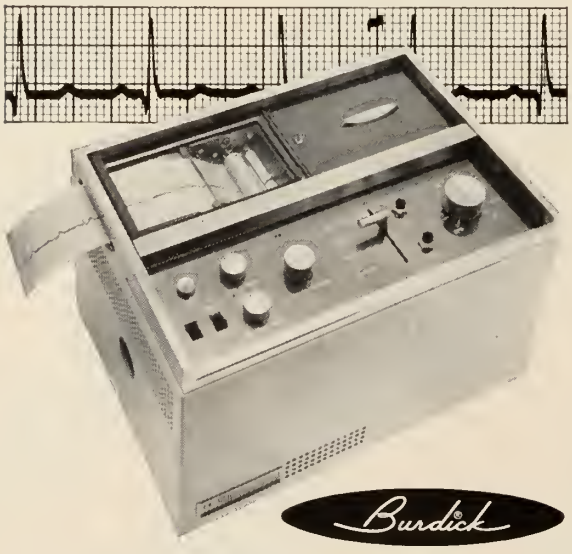
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cal societies to take the leadership in establishing such training courses for interested adults.

Supports "Operation Hometown"

The year 1964, being an election year, it is believed that President Johnson will certainly employ the same tactics as his predecessor, in making care for the aged a political issue. The American Medical Association has initiated a national legislative program for County Medical Societies called "Operation Hometown." You will hear a great deal about this ambitious program and YOU will be expected to take an active part in the fight to save American medicine through participation in "Operation Hometown."

The year of 1964 will be a busy one on the legislative front. ALL of us, not just the Legislative Committee, must be prepared to fight the programs which are designed to enslave us.

Quoted from article by
JACK HOOGERHYDE, M.D., in
The Bulletin, Kent County, January, 1964

Would Help County Societies



Efforts are under way to establish a Committee on Medicine and Religion in each county medical society to increase the teamwork between physicians and clergymen. The new MSMS Committee, which will assist the county committees, is under the chairmanship of R. L. Rapport, M.D., *(right)*, Flint. He is shown conferring with Rev. Dr. P. B. McCleeve, director of the AMA Department of Medicine and Religion. Members of the MSMS Committee include W. C. Beets, M.D., Grand Rapids; R. R. Cooper, M.D., Grosse Pointe; R. A. Frary, M.D., Monroe; A. E. Heustis, M.D., Lansing; D. V. Sargent, M.D., Saginaw; R. W. Teed, M.D., Ann Arbor; J. R. Dehlin, M.D., Gladstone.

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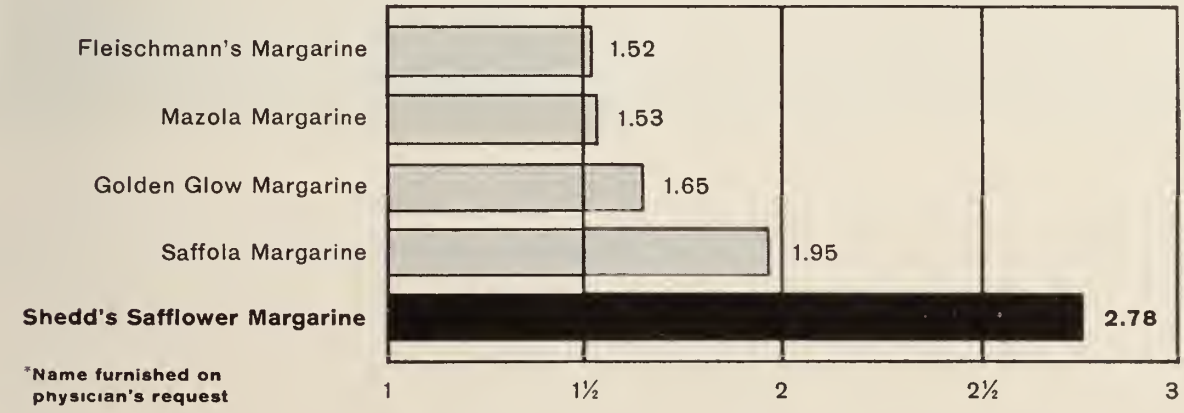


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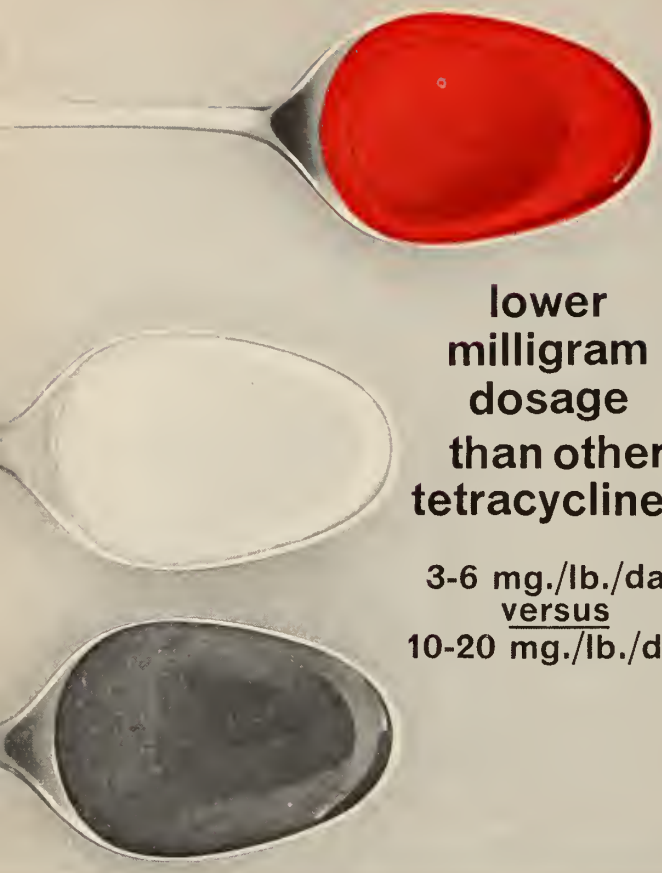
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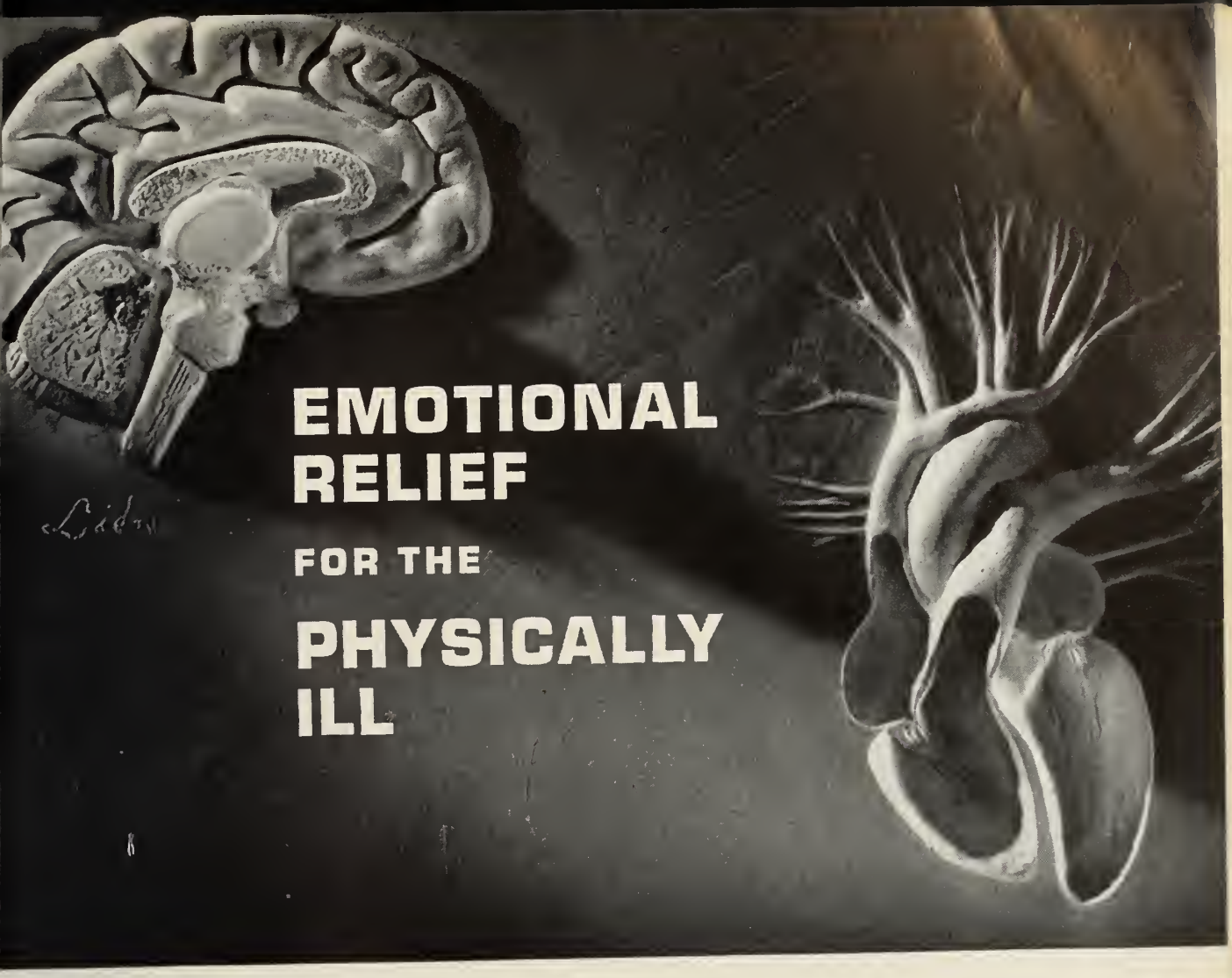
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Selecting the proper phenothiazine in treatment of psychotic symptoms has become an increasingly perplexing problem. Not only have many brands been marketed, but also, various forms have been issued which produce varying clinical effects. With the view toward increasing therapeutic efficacy, we proposed to determine whether or not certain anti-psychotic drugs were significantly effective against certain specific psychiatric symptoms. A random sampling of 225 patients admitted with the diagnosis of schizophrenia was reviewed to determine the nature of the admitting symptoms, the medication used and the dosage given. We proposed to test the hypothesis that chlorpromazine was specific for treating "delusional" patients and trifluoperazine and perphenazine were specific for treating "depersonalization" patients. An analysis was made of the clinical success or failure obtained by following the hypothesis.

Symptom Specificity Of Anti-Psychotic Drugs

Sidney B. Jenkins, M.D. and Anne H. Samborski, M.D.
Eloise, Michigan

THROUGHOUT our eight-year experience with the use of the phenothiazines and related drugs, we have seen their role in our hospital shift from that of calming agents to that of curing drugs. That is, if by curing, we mean reversing the blatant pathology rather than the complete elimination of predisposition to disturbed psychophysiological function.

Barsa[3] as early as 1957 noted the anti-psychotic effect of some of the psychiatric drugs. He listed in order of decreasing anti-psychotic effect, phenothiazines, rauwolfia, meprobamate and diphenyl methanes. Our clinical trials of various psychiatric drugs appear to confirm his impression.[5,6,19-22] The anti-psychotic effect has to varying degrees been found consistently by us to be produced by chlorpromazine, perphenazine, prochlorperazine, trifluoperazine and triflupromazine either alone or in combination.

Himwich[15] agreed that tranquilizers corrected certain schizophrenic symptoms. He compared the advances made with tranquilizers with the advent of insulin, which also counteracted only the symptoms of diabetes without removing the cause.

With the view toward increasing therapeutic efficacy, we proposed to determine whether or not certain anti-psychotic drugs showed significant effectiveness in the treatment of specific psychiatric symptoms, thereby allowing the drug to be matched to the appropriate symptom.

The specific symptoms considered were: alteration in interpretation of bodily sensations and configurations (depersonalization) and alteration in concept formation with projection of distorted ideas.

In brief, the hypothesis would be confirmed if successful treatment could be achieved by treating the

Doctor Jenkins is Director, Male Psychiatric Division, Wayne County General Hospital.
Doctor Samborski formerly was Staff Psychiatrist, Wayne County General Hospital.

"paranoid" (delusional) group with chlorpromazine and the "catatonic" (depersonalization) group with trifluoperazine and perphenazine.

Method

Every third name was taken from a roster of 225 patients listed in alphabetical order who were admitted to our hospital between October 1, and December 31, 1960, with the diagnosis of schizophrenia. The case histories were reviewed to determine the nature of the admitting symptoms, the medication used and the dosage given. It was then determined which of these people were discharged and which were still in the hospital at the end of a first six-month period. The list of patients readmitted during a second six-month period with this diagnosis, was studied to see if it contained the names of those in the experimental group. Because of the special after-care arrangements at our hospital, we would expect that practically all of our discharges if rehospitalized would return to our hospital.

Patients were divided as to symptom criteria and drug dosage criteria. Minimal effective dose of chlorpromazine was arbitrarily set at four hundred milligrams per day. Patients receiving ten milligrams of trifluoperazine and eight milligrams of perphenazine were considered to have received a minimal effective dose. An analysis was made of the degree to which the treatment success was influenced by treating "delusional" patients with chlorpromazine and by treating "depersonalization" patients with trifluoperazine and perphenazine.

In our experiment a success was a person who not only showed remission of his psychotic symptoms but also was able to remain in his home community at least six months. A failure was a person who for any reason had to be readmitted to our psychiatric division before six months had elapsed. These individuals secured immediate admission either through emergency, 48-hour or five-day orders.

Results

A breakdown of patients by diagnosis shows the paranoid type is the largest group. It was expected that the undifferentiated group would have been larger since so many patients do have poorly defined symptoms. Catatonics appear to have steadily declined and hebephrenia is rare as an admitting diagnosis at our hospital. Prior to the introduction of the phenothiazines, the paranoid type was looked upon unfavorably because of the persistence of delusional ideas. Note the high number of successes in our group. All 75 of these people were discharged from the hospital (Table I).

Table I.

TOTAL NUMBER IN THE GROUP STUDIED BROKEN DOWN ACCORDING TO DIAGNOSIS AND SUCCESS OR FAILURE OF TREATMENT

Schizophrenic	Success	Failure	Total
Paranoid	37(86%)	6(14%)	43
Chronic Undifferentiated	21(87.5%)	3(12.5%)	24
Catatonic	4(57%)	3(43%)	7
Schizoaffective	1(100%)	0	1
Totals	63(84%)	12(16%)	75

When we study the chart of success according to medication, we note good success with chlorpromazine (Thorazine) alone and in combination with trifluopera-

Table II.

CASES SUCCESSFULLY TREATED TABULATED ACCORDING TO MEDICATION

	Chlorpromazine	Trifluoperazine	Perphenazine	Rauwolfia	Combinations	No Tranquilizer
Success	26 (83.9%)	9 (75%)	3 (100%)	1 (100%)	23 (85%)	1 (100%)
Failure	5 (16.1%)	3 (25%)	0	0	4 (15%)	0
Totals	31	12	3	1	27	1

Table III.

BREAKDOWN OF CASES SUCCESSFULLY TREATED AS TO DIAGNOSIS AND MEDICATION

Schizophrenic	Chlorpromazine	Trifluoperazine	Chlorpromazine and Trifluoperazine	Rauwolfia	Perphenazine	Trifluoperazine and Trifluopromazine	Perphenazine and Prochlorperazine	No Medication
Catatonic	1	0	3	0	0	0	0	0
Paranoid	16	6	11	0	2	1	0	1
Chronic Undifferentiated	8	3	6	1	1	1	1	0
Schizoaffective	1	0	0	0	0	0	0	0

zine (Stelazine). Since many of these patients were started on the combination shortly after admission, we still do not know whether or not they would have remitted on chlorpromazine alone (Table II).

Success with paranoids is notable when treated with chlorpromazine alone or in combination with trifluoperazine. Again we cannot say whether or not the combination was needed. Many advocate the combination when a large (+1200 mgm.) dose of chlorpromazine appears to be needed (Table III).

If we ignore the questionable cases, we see we have a fairly even split between those confirming and those not confirming the hypothesis. Those listed in the questionable column are those with either delusional or depersonalization symptoms who were treated with the combination. Cases listed here did not have to meet minimal dose criteria (Table IV).

Table IV.

SUCCESS AND FAILURE OF TREATMENT SHOWING RELATIONSHIP TO HYPOTHESIS

	Confirms	Does Not Confirm	Question-able	Remarks
Success	22	22	19	One patient improved on no medication
Failure	3	9	0	

Those listed in Chart V had to meet minimum medication and clinical symptom criteria (Table V).

Table V.

RELATIONSHIP TO HYPOTHESIS OF CASES FOLLOWING MINIMUM MEDICATION AND CLINICAL SYMPTOM CRITERIA

	Confirms	Does Not Confirm	Questionable
Success	18	14	11
Failure	3	6	0

Paranoid symptoms show a general good response to phenothiazines (Table VI).

Table VI.

IS CHLORPROMAZINE SPECIFIC FOR PARANOID SYMPTOMS?

	Chlorpromazine	All Others Medications	Chlorpromazine and Trifluoperazine
Success	16	10	11
Failure	4	1	1

This chart shows that minimal dose criteria are not necessarily connected with possibility of success (Table VII).

Table VII.

CASES TREATED SHOWING RELATIONSHIP TO CRITERIA FOR MINIMUM MEDICATION AND CLINICAL SYMPTOMS AND HYPOTHESIS

	All	Following Criteria	Not Following Criteria	Following Criteria and Confirming Hypothesis
Success	63	43	20	18
Failure	12	9	3	3

Predicted successes also show an even split, indicating that this is not a valid method of predicting success (Table VIII).

Table VIII.

CASES SUCCESSFULLY TREATED

As Predicted	Contrary To Prediction	Results Questionable	Remarks
22	22	19	One patient improved on no medication

Predicted failures also split fairly evenly (Table IX).

Table IX.

FAILURES OF TREATMENT

As Predicted	Contrary to Prediction	Results Questionable	Remarks
4	6	2	1. One in this group treated with EST.
1, 2, 3.	4, 5.		2. One in this group refused medication.
			3. Two of this group had only one drug of combination.
			4. One in this group refused medication.
			5. One in this group had a maximum dose of 50 mg. Chlorpromazine t.i.d.

Table X.

FACTORS INFLUENCING FAILURES

Patient	Sex	First Admission Here	This Period	Employed	Family Acceptance	Social Acceptance	Follow Up	Taking Medicine	Remarks
Truck driver	M	34	34	Yes	Yes	Yes	Yes	Yes	Divorced and lost job during course of illness.
Machine operator	F	18	33	Yes	Yes	Yes	Yes	Yes	
Tool maker	M	27	27	Yes	Yes	Yes	Yes	Yes	Made poor adjustment immediately on release
Car wash	M	19	19	Yes	Yes	Yes	No	No	
Housewife with three children	F	26	26	—	Yes	Yes	Yes	No	
Cashier	M	39	40	Yes	Yes	Yes	No	No	Many admissions. Refused to take medication.
Housewife with two children	F	33	34	—	Yes	Yes	—	No	
Welder	M	48	49	Yes	No	Yes	—	—	Got better job in interval between hospitalizations.
Crane operator	M	37	37	Yes	Yes	Yes	No	No	
Clerk	M	22	23	No	Yes	Yes	Yes	—	Turned down for job— "Health reasons."
Odd jobs	M	19	19	No	Yes	Yes	Yes	No	
Housewife with five children	F	32	38	—	—	—	No	No	Widow on Social Security and ADC. Refused to see doctor.

Analysis of failures shows that none of the factors stand out as being significant in precipitating failure. Not taking medication is strongly suggested as a factor (Table X).

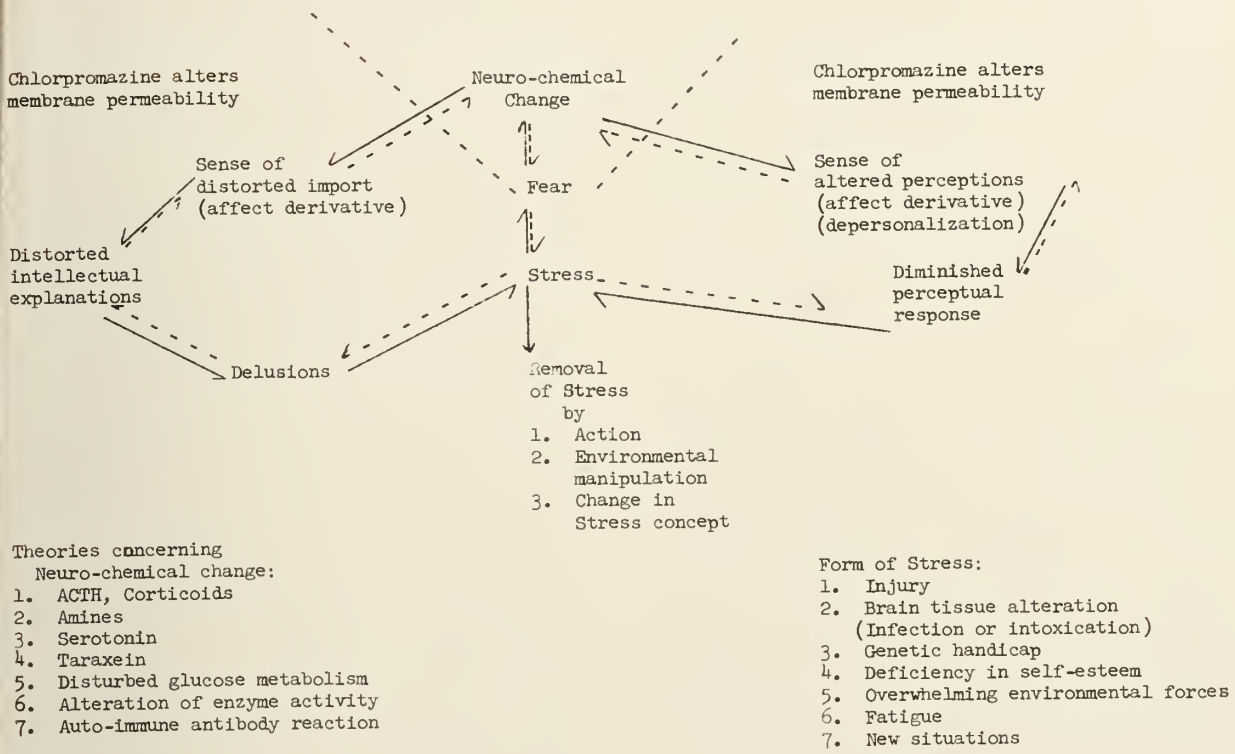
Discussion

In our study, we were measuring specific effects of these medications on a mental state called psychosis. We defined psychosis as a condition produced by a disease which renders an individual incapable of coping with his outside world in a purposeful or meaningful manner. The particular disease schizophrenia we did not define as being synonymous with psychosis. Instead we considered it a disease of the affect and thought which in its most severe form rendered an individual incapable of coping with his outside world in a purposeful or meaningful manner and in its milder forms caused an imbalance between thoughts and feelings and produced an alteration in concept formation. Our definition is still close to Bleuler's[7] description of schizophrenia as being a disease in which the fundamental symptoms consist of disturbance of association and affectivity, the predilection for fantasy as against reality and the inclination to divorce oneself from reality.

In defining the catatonic type of schizophrenia, we incorporated the phenomenon of depersonalization as discussed by Goldston[12] and later by Saperstein.[25] We considered depersonalization a state in which there is prolonged disturbance of interpretation of bodily sensations. Bleuler was reluctant to include this syndrome in any specific disease type. He attributed the experience to an alteration in emotional emphasis, rather than to a disturbance of sensation. In catatonia he placed emphasis on stupor and excitement. We tested our hypothesis using a definition emphasizing symptoms of depersonalization. We defined the catatonic type as a form of schizophrenia in which alteration in affect or interpretation of bodily sensation is the predominating symptom. Our results show that this portion of the hypothesis was particularly weak. This would tend to add support to Bleuler's conclusion. We may, therefore, conclude that depersonalization is an early non-specific symptom rather than specifically catatonic.

Bleuler describes the paranoid as a patient who is suspicious, refers indifferent events to himself and has hallucinations of bodily sensation. We preferred to consider the thought processes in our definition. We described the paranoid type as being that type of schizophrenia in which loosening of association, alteration of concept formation and projection of distorted ideas predominated. The chronic undifferentiated type was defined as containing a mixture of these symptoms

Table XI



with a constant shifting back and forth between symptoms. Affect was defined as the manifestation of the balance or imbalance between feeling state and ideas.

Although seven anti-psychotic drugs were received in various doses by patients involved in the survey, only chlorpromazine, trifluoperazine and perphenazine were used with any great frequency. To further define limits of our hypothesis, we set minimum daily dose standards of 400 mg. for chlorpromazine, 10 mg. for trifluoperazine and 8 mg. for perphenazine. A combination consisted of a minimum of 300 mg. of chlorpromazine and 6 mg. of trifluoperazine.

Our minimal dose was close to the 500 mg. of chlorpromazine recommended by Ayd[2] for minimal effectiveness. We do find that doses of chlorpromazine below 200 mg. as suggested by Kehoe and Pollard[17] have a significant anti-psychotic effect. This appears to be due to individual variation, with patient size and sensitivity being important factors.

The effective remission period of six months closely parallels Denber and Bird's[10] observation that chronic patients must be treated longer than seven months.

Our over-all treatment program is geared toward the early return of the patient to his home and place of employment. We agree with Cohen and Clancy[9] that the place for working out the situation that precipitated the original conflict is the home, provided a well medicated patient is supported by psychotherapy which helps him adjust to the ever changing family.

Psychotherapy can be neither discounted nor can it be credited with being a major factor in bringing about schizophrenic remission. Newbold and Steed[24] noted that the close psychotherapeutic relationship demonstrated that all patients showed evidence of marked accentuation of feelings when chlorpromazine was discontinued. Hostility in one patient, which was previously controlled, became incapacitating when chlorpromazine was discontinued. They were forced to conclude that if the disturbance of the patient was too great, psychotherapy was impeded or ineffective. On the other hand, they stated that unless some disturbance was experienced as discomfort, the patient was not motivated for psychotherapy. Lesse[23] reported that a strong transference was established rapidly when the patient was on chlorpromazine. Negative transferences were blunted. He found rapid decompression of anxiety in a few instances had a very deleterious

effect on therapy. Some patients who had persistently denied any emotional difficulties prior to the final emotional crisis, reverted back into this pattern after the tension was greatly relieved and "ran away from treatment." He found that chlorpromazine affected the affectual impact of dreams. Manifest content was the same but it was denuded of rage and terror.

Our results indicate that there was significant change in the psychotic symptoms. The suggestion of support for our hypothesis does not check out statistically. Chlorpromazine and trifluoperazine, both alone and in combination, have notable effect on both types of symptoms.

If we consider only chlorpromazine which has been more thoroughly studied, we might formulate a theoretical scheme explaining how it brings about changes in the schizophrenic psychopathology (Table XI).

An individual encountering a stress may choose several methods of handling it. He may act against it directly. He may alter his environment. He may change the way he thinks about the stress. But, if the stress persists, fear is aroused. This fear produces certain chemical changes throughout the body. Korchin and Herz[18] demonstrated that even the stress of a new situation would cause a demonstrable increase in plasma hydrocortisone. Hetzel et al[14] state that feelings states described by the subjects as apprehension, dread, exhilaration or excitement have been found to be associated with increases in 17-hydroxycorticoid excretion. Various theories have been presented for the kinds of neurochemical change taking place in the body of an individual experiencing a psychotic episode. The effect of altered metabolism of amines (Axelrod et al[1]) or adrenochrome (Hoffer[16]) or serotonin (Brodie, Pletcher et al[8]) have been discussed by many authors besides those listed. The presence of a serum substance called taraxein is mentioned by Heath[13] and his group. Alteration of glucose metabolism (Beckett, Senf, Frohman et al[4]) and enzyme activity (Spirles et al[26]) has been mentioned. Just recently Fessel[11] related autoimmune antibody reactions to production of psychotic episodes.

Without knowing the specific neurochemical change, we do have some evidence of chlorpromazine effects. Spirles and his associates have shown that:

1. The phenothiazines, such as chlorpromazine, used in therapy appear to effect membranes in the main biological systems.
2. The metrazol-enhanced passage of dyes into the brain is antagonized by chlorpromazine.
3. Chlorpromazine membrane effects are slowing or preventing substrate uptake or changing enzyme leakage from mitochondria.
4. Chlorpromazine considerably inhibits all types of swelling.
5. The absorption of sugar from the intestines and drugs from subcutaneous depots are both retarded by chlorpromazine.

This effect of chlorpromazine on membrane possibly diminishes the effect of neurochemical changes on affect derivatives such as sense of import and perception, thereby allowing the organism to more realistically evaluate the stress. Were the changes to persist, the organism would be faced with the problem of explaining the distorted sense of import by delusions. It would also try to avoid sensing altered perceptions by diminishing the need for perceptual response by withdrawing. Such responses would in turn increase the stress. The cycle would be started all over again.

If we accept the membrane effect of phenothiazines, we can see why experimentally, we would not have a statistically significant difference in the response for acute patients whether distorted sense of import or a sense of altered perceptions is the prominent symptom.

Our results suggest that chlorpromazine is more specific for delusions than are other anti-psychotic drugs for depersonalization.

Our study of the failures show the continuing importance of post-hospitalization, drug maintenance without tending to minimize the importance of psychotherapy and family case work.

Patients with a favorable home situation and a psychological reaction to an acute definable stress, can be adequately followed by the general practitioner in spite of the existence of some basic ego pathology.

Conclusions

1. The anti-psychotic effect of chlorpromazine and trifluoperazine was confirmed.
2. Both chlorpromazine alone and chlorpromazine and trifluoperazine in combination showed notable effect on delusional symptoms.
3. We were unable to demonstrate at a level of statistical significance that any anti-psychotic drug was more specific for symptoms of depersonalization than for delusional symptoms.
4. Case studies suggest that depersonalization is an early non-specific psychotic symptom.
5. We have presented a theory explaining how chlorpromazine effects schizophrenic psychopathology.

Summary

The case histories of seventy-five patients admitted with diagnosis of schizophrenia were reviewed. An attempt was made to determine whether the choice of specific psychiatric drugs for specific symptoms would effect significantly the success or failure in treatment of the psychosis.

Factors affecting recovery were considered.

A theory relating to the mode of antipsychotic action of chlorpromazine was discussed.

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A Study Trip with Students to the United States

The next day, we traveled to Ann Arbor in the State of Michigan. The visit there was a great event. Everywhere we had been greeted with the greatest cordiality and friendliness, but in Ann Arbor this cordiality was altogether overwhelming. Ann Arbor is a real university city with 67,000 inhabitants and 20,000 students. There are only a few small industries. Aside from this, the city is one big university. When we arrived, we were greeted in the Amphitheater of the Medical Science Building by Dean Hubbard in the presence of a large group of faculty members and many students. On one wall stood in big multi-colored letters "Welcome to Ann Arbor"—in Swedish! It was striking how many of the physicians had been in Sweden and several could therefore speak Swedish more or less.

One American student was assigned to take care of a Swedish student for the whole period, and he arranged to show that student whatever interested him at the Hospital the next day. In the evening of the first day, each Swedish student was invited to some professor's home. As a rule, each professor invited four Swedish and four American students. The next forenoon, the Swedish students visited the University Hospital under the guidance of his American comrade. Jan Sandegard attended a seven hour blood vessel operation, and Kerstin Tidestrom watched a professor closing a tracheo-esophageal fistula in a new-born child. Others visited the Anesthesia, Gynecology, and other departments. A very pleasant and worthwhile forenoon for everyone. After luncheon, which took place in the hospital, there was a tour of the city during which we were impressed among other things by the Stadium which accommodated 100,001 spectators.

In the evening, a professor, who owned a big farm outside the city, put on a picnic for the Swedish and American students and professors. On the field, the students played football and baseball and danced folk dances. In an adjacent woods, there was a big camp fire burning. Here hamburgers, hot dogs, and roasted corn were served. An unforgettable evening.—Extract from an article by Einar Ljunggren in *Svenska Lakartidningen*, 60:3086, 1963.

Acid-Base Abnormalities In Refractory Hypotension

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THE STATE of severe shock is characterized by a progressive failure of the peripheral circulation. As a consequence, several abnormalities of acid base balance develop. While these changes are invariably the result of the shock state, they often serve to perpetuate it if uncorrected. The acid-base abnormalities now to be discussed were found in patients with severe illnesses characterized by hypotension which was refractory to the usual modes of treatment. In several instances, the severity of the illness was such that there was little hope of survival.

When the patient is first seen and judged to be a suitable candidate for the study, an anaerobically drawn, heparinized arterial blood sample is immediately sent to the special laboratory associated with the Shock Study Unit. There the pH, PCO_2, standard bicarbonate, total buffer base, and base excess or deficit are determined.[1] The Astrup unit is utilized for this purpose. Although there has been some recent criticism of standard plasma bicarbonate and the base excess in the evaluation of acid-base deficiencies, in our hands at least, they have been of definite value in the overall assessment of the patient.[2] These studies are repeated during the subsequent hospital course as often as judged necessary. At the same time that the acid base deficiencies are corrected, blood volume, fluid and electrolyte deficiencies are also managed. Metabolic acidosis was the most common abnormality and was encountered in nine of the 18 patients (Table I).

Metabolic Acidosis

Although the acidosis was not usually responsible for the hypotension, it contributed to the continued deterioration of the patient. It has been well documented that in the presence of acidosis the blood vessels become refractory not only to exogenous vasopressor, but also to their endogenous catecholamines.[3,4,5] For this reason, the acidosis should be promptly corrected. Occasionally, the restoration of an adequate blood volume will allow an adequate tissue perfusion and thus a spontaneous correction of metabolic acidosis.

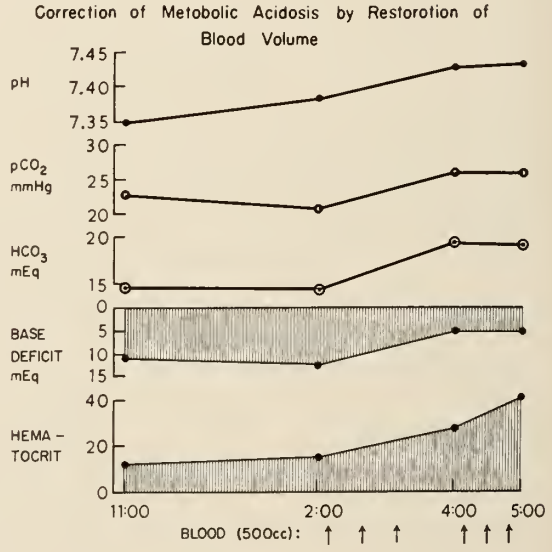


Fig. 1. Correction of metabolic acidosis by restoration of blood volume.

(a) *Correction of Severe Metabolic Acidosis by Replacement of Red Cell Mass*

Case 1.—H.A., No. 463560, a 16-year-old Negro girl, was admitted to Detroit Receiving Hospital on June 24, 1963, with a five-day history of self-induced abortion. She was having chills, fever and progressive weakness since that time. Physical examination on admission revealed marked icterus, temperature 103.8 degrees F., pulse 160, and blood pressure 100/50. There were rales at the left lung base, heart sounds were distant, and there was pitting ankle edema.

Because of the patient's precarious state, she was transferred to the Shock Unit. Initial laboratory determinations revealed marked deficiency of red cell mass as well as a compensated metabolic acidosis (Fig. 1). The patient was treated with whole blood, given a total of 6 units packed

From the Robert S. Marx Laboratories of Surgery, Wayne State University College of Medicine, Department of Surgery, and Detroit Receiving Hospital.

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THAM supplied as Talatrol by the Abbott Laboratories.

Table I

ORIGINAL ACID BASE ABNORMALITIES

Patient	Diagnosis	pH	PCO_2 (mm Hg)	Standard HCO_3 (mEq)	Interpretation
456588	Intestinal obstruction	7.26	41	17.5	Metabolic acidosis
449236	Gastric ulcer with generalized peritonitis	7.28	33	17	Metabolic acidosis
454506	Perforated intestinal obstruction with generalized peritonitis	7.28	39	18	Metabolic acidosis
456447	Dissecting aortic aneurysm	7.31	30.5	16.7	Metabolic acidosis
461314	Septic abortion	7.35	19	14.5	Metabolic acidosis
(Case 6) 299296	Intestinal obstruction	7.22	30	13.8	Metabolic acidosis
451505	Septic abortion	7.30	33	15	Metabolic acidosis
(Case 3) 96005	Gangrenous small bowel	7.38	27	17.7	Compensated metabolic acidosis
(Case 1) 463560	Septic abortion	7.35	22	14.5	Compensated metabolic acidosis
283579	Gangrenous small bowel	7.32	52	21.5	Combined metabolic and respiratory acidosis
(Case 4) 458715	Bleeding duodenal ulcer	7.31	45	21	Combined metabolic and respiratory acidosis
(Case 2) 456128	Ruptured abdominal aortic aneurysm	7.25	59.5	22.2	Combined metabolic and respiratory acidosis
(Case 5) 454237	Ruptured abdominal aortic aneurysm	7.39	52	27.5	Compensated respiratory acidosis
451504	Ruptured duodenum and pancreas	7.45	55	29.5	Compensated respiratory acidosis
453050	Carcinoma of prostate E. coli septicemia	7.47	30	21	Respiratory alkalosis
459853	Empyema of gallbladder Aerobactor septicemia	7.44	31	22.5	Respiratory alkalosis
(Case 7) 451713	Ruptured appendix with generalized peritonitis	7.45	34	24	Respiratory alkalosis
451142	Bleeding marginal ulcer	7.49	61	33	Metabolic alkalosis

cells, which resulted in marked improvement in her base deficit. Approximately eight hours later, her condition having stabilized, she was taken to surgery, where a hysterectomy was performed. The patient became severely hypotensive during surgery, refractory to all treatment, and postoperatively developed severe pulmonary insufficiency with rising PCO_2, and expired shortly after surgery. The removed surgical specimen showed evidence of endometritis, and the autopsy demonstrated multiple pulmonary abscesses.

The marked red cell deficit in this patient was in all likelihood related to a circulating hemolysin, possibly of clostridial origin. Metabolic acidosis was completely corrected by replacement of the red cell mass. The mechanism involved here is presumably due to the improved oxygen transport and also the provision of significant hemoglobin buffer and finally the restoration of renal function. It is of considerable interest that terminally this patient was in severe respiratory difficulty with a PCO_2 of 120 mm Hg. whereas only 8 hours previously she had been able to compensate for a metabolic acidosis by reducing her PCO_2 to 21. During the terminal course of her illness, pulmonary compliance was so reduced that she could no longer be ventilated by means of the Bennett respirator. Terminal pulmonary failure has proven a common event in severe septic shock in man.

(b) *Correction of Metabolic Acidosis with Buffer Agents*

In this series of patients, either sodium bicarbonate or the amine buffer, trishydroxyaminomethane (THAM) were used to correct the acidosis. The advantages of sodium bicarbonate are (1) It may be administered as a concentrated solution (40 mEq. per 50 cc) and thus avoid adding further fluid to an overhydrated patient, or it may be given in dilute solutions with the intravenous requirements. (2) It is rapidly liberated by the lungs and kidneys. Its principal disadvantages are (1) It may add a sodium load to a patient with marginal cardiac function. (2) The carbon dioxide must be eliminated by the lungs. In the

presence of pulmonary insufficiency this results in a respiratory acidosis. (3) Theoretically sodium bicarbonate is only an extracellular buffer and would not readily correct intracellular acidosis.

was required. At the conclusion of the operation, the patient had evidence of a bleeding tendency with continuing oozing from all retroperitoneal surfaces as well as the wound edge. The procedure was terminated. The patient was initially fairly stable with a blood pressure of 120/70, but in the

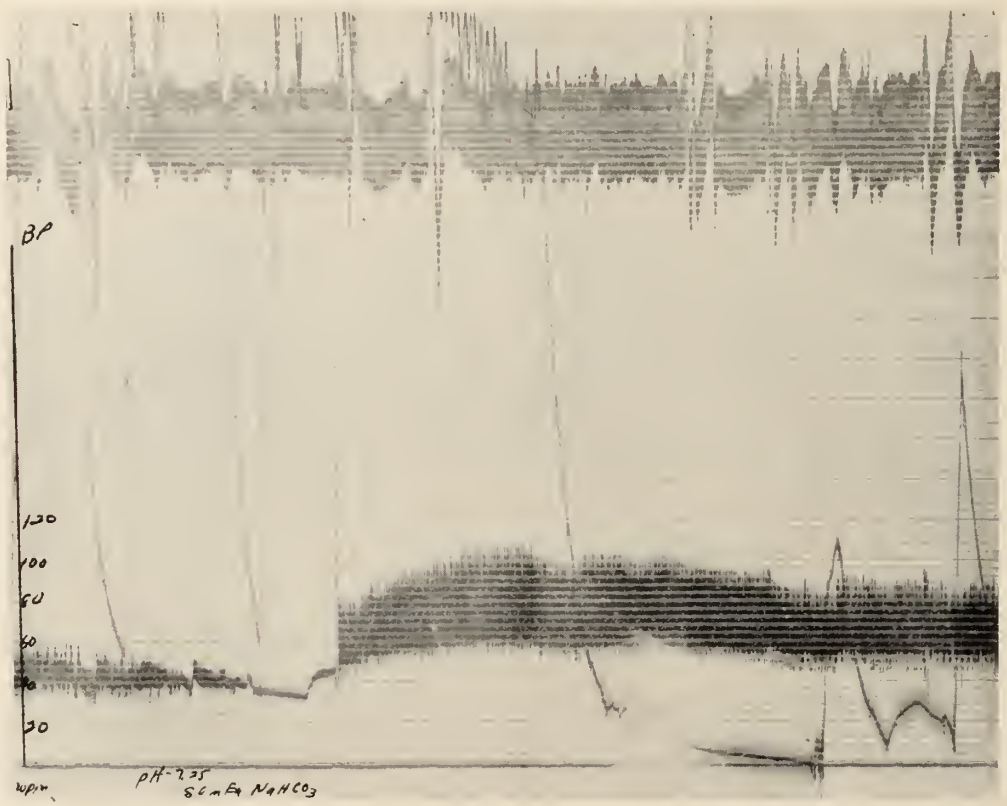


Fig. 2. Pressure response to correction of severe acidosis with $NaHCO_3$.

Pressor Response to Correction of Severe Metabolic Acidosis with Sodium Bicarbonate

Case 2.—C.S., No. 456128, a 69-year-old white man, was admitted to the Emergency Room of Receiving Hospital with a sudden onset of severe back and right flank pain radiating down his right leg and to his right testicle. On admission to the Emergency Room, he was hypotensive, blood pressure 70/50, pulse 120, and was complaining of excruciating back pain. The rest of physical examination was normal except for the abdominal examination which revealed a tender, pulsating mass filling the epigastrium extending to the right side. Femoral pulses were palpable bilaterally. During the course of the examination, the patient became profoundly hypotensive with no blood pressure, and a clinical diagnosis of ruptured abdominal aortic aneurysm was made. The patient was rapidly transfused with blood until his pressure reached 100 systolic and was taken to the Operating Room. At surgery a large abdominal aortic aneurysm which had ruptured retroperitoneally and extended to the right was found. This was rapidly resected, a Teflon bifurcation graft was inserted and functioned well. A total of 20 units of blood Recovery Room he became severely hypotensive and was transferred to the Shock Study Unit where it became apparent that he had developed a generalized bleeding tendency. Original acid-base determinations revealed a severe combined acidosis with a pH of 7.25, PCO_2 of 59.5, standard bicarbonate of 22. Immediately a tracheostomy was performed and the patient placed on a Bennett respirator with only very transient improvement and continued severe hypotension. He was then given 80 mEq of sodium bicarbonate with an immediate pressure response (Fig. 2). The response was only temporary. The generalized bleeding tendency became more pronounced, and in spite of the patient requiring blood, vasopressors and continuing doses of sodium bicarbonate, he became completely anuric and expired approximately eight hours postoperatively.

This case demonstrates the pressor response produced by a temporary correction in pH in a patient with an uncompensated respiratory acidosis and a mild metabolic acidosis. Like many patients in severe shock, pulmonary and myocardial failure complicate the pic-

ture and produce a state which is presently uncorrectable.

(c) *The Use of THAM in Treatment of Shock*

THAM is an excellent buffer and rapidly diffuses through the extracellular fluid as well as into the cell.[6,7] It is also an osmotic diuretic and thus aids in preventing the oliguria which is so often present in shock. It is rapidly excreted in urine, especially in the presence of excess bicarbonate, approximately 60 per cent being recovered unchanged in the urine in 24 hours.[8] THAM does not add a further sodium load to the body and does not add to the body store of carbonic acid. The principal disadvantage in the use of THAM is that it is a potential respiratory depressant and respiratory assistance is frequently required.[9] A Bennett intermittent positive and negative pressure respirator is kept at the bedside and used when indicated. Ventilation is preferably assisted with a tracheostomy and a cuffed endotracheal tube, although a face mask may be utilized for short term use. A theoretical disadvantage in the use of THAM is the possibility of causing further vascular collapse in a patient who is hypotensive. This has been reported to occur in dogs with endotoxin shock.[10] In these instances, although the acidosis was corrected, and diuresis begun, THAM was of no overall value and actually tended to cause early demise of the animals. THAM also appears to enhance the action of insulin and may cause hypoglycemia especially if the patient is depleted of carbohydrate stores or if it is used for prolonged periods.[11]

Respiratory Depression with THAM

Case 3.—M.B., No. 96005, a 69-year-old, markedly obese Negro woman, was admitted to Receiving Hospital with a five-day history of mechanical small bowel obstruction caused by adhesions. At the time of operation, a gangrenous loop of small intestine, approximately 18 inches in length, was resected. During and prior to the surgery, patient had adequate replacement of blood volume but required phenylephrine in the postoperative period to maintain blood pressure. The patient was then transferred to the Shock Study Unit. The initial acid-base studies showed a compensated metabolic acidosis (Fig. 3). Thirty-six grams of THAM were given over a period of approximately one and a half hours, and during this period a definite respiratory insufficiency developed, resulting in a further fall in the pH and elevation of the PCO_2. A tracheostomy was performed and a respirator required to assist ventilation. Sodium bicarbonate was used to correct the acidosis, but in spite of assisted ventilation, the patient had a continuing rise in PCO_2 and increasing pulmonary resistance. The respirator could not be discontinued and the patient expired of pulmonary insufficiency approximately 48 hours following her operation. Permission for autopsy was not obtained.

Combined Metabolic and Respiratory Acidosis in Shock

A more serious and difficult form of acidosis was encountered in 3 patients. This consisted of a combined metabolic and respiratory acidosis and was seen in the most critically ill, often moribund, patients. The general plan of management was to correct the metabolic deficit with sodium bicarbonate or THAM and to manage the respiratory problem with a tracheostomy and Bennett respirator. These patients were also given full digitalizing doses of digoxin in the hope that cardiac output might be improved and pulmonary congestion decreased. Increasing central venous pressure or frank pulmonary edema were indications for the application of rotating tourniquets or phlebotomy. The results in treating combined acidosis were discouraging. None of these patients survived.

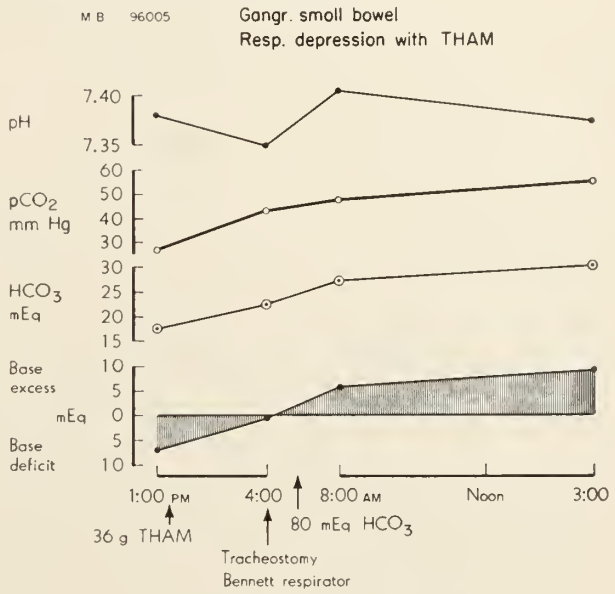


Fig. 3. Respiratory depression following THAM.

Combined Metabolic and Respiratory Acidosis

Case 4.—W.C., No. 458715, a 57-year-old, obese white man with known pulmonary emphysema and fibrosis was originally admitted to the hospital with a bleeding duodenal ulcer. Because of persistent bleeding, a vagotomy, pyloroplasty, and ligation of the large posterior duodenal ulcer was performed on the fourth post-admission day. For the next three days, the patient did well. On the fourth postoperative day, he re-bled massively from his ulcer and went into profound shock. Eight units of whole blood were rapidly infused, and the patient was taken back into the Operating Room and had a hemigastrectomy Billroth II for a bleeding pancreatoduodenal artery in the base of the ulcer.

In the immediate postoperative period, the patient was stable and electrolyte acid-base studies were normal, but approximately six hours later, he became hypotensive, hyperpneic, and developed severe acidosis with a fall in the bicarbonate

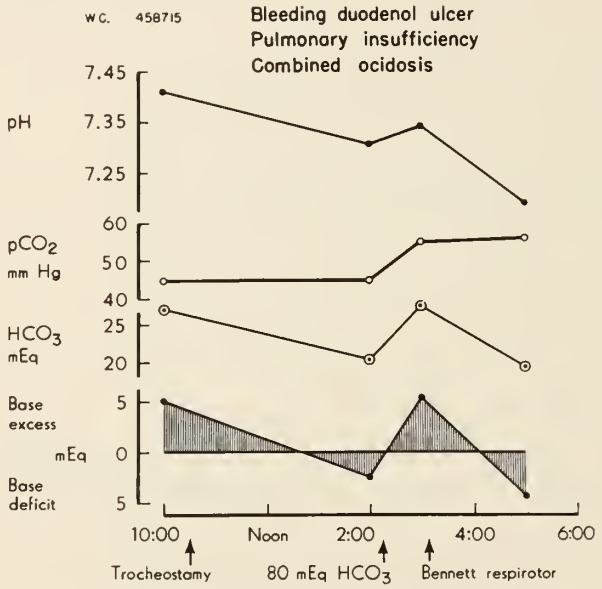


Fig. 4. Combined metabolic and respiratory acidosis. Terminal pulmonary failure.

but a continued elevation of the PCO_2 (Fig. 4). In spite of the administration of sodium bicarbonate to correct the metabolic acidosis, and the use of the Bennett respirator to increase the ventilatory efficiency, the patient experienced progressive deterioration and continued rise of his PCO_2 and expired 8 hours postoperatively. At postmortem examination, the patient had pulmonary edema, pulmonary emphysema and fibrosis. The abdominal examination revealed a subtotal gastrectomy with blood in the distal gastrointestinal tract, but no evidence of continuing bleeding.

Respiratory Acidosis

A third form of acidosis was seen in this group of patients with a purely respiratory acidosis. This was due essentially to inadequate pulmonary ventilation and the accumulation of carbon dioxide. Both the patients with this abnormality had had long operations and massive transfusions. Tracheostomy and adequate tracheobronchial cleansing rapidly improved their clinical status, and their chemistries promptly returned to normal.

Respiratory Acidosis

Case 5.—G.M., No. 454237, a 69-year-old, white man, was admitted to the hospital in severe shock for several hours with retroperitoneal rupture of abdominal aortic aneurysm. He was taken immediately to the Operating Room and had resection of the aneurysm and a Teflon bifurcation graft inserted. He required 23 units of blood during and after operation, and in the postoperative period he required intermittent doses of Metaraminol to maintain blood pressure. Initial acid base studies show significant respiratory acidosis (Fig. 5). Tracheostomy was performed and adequate tracheobronchial cleansing was possible. This resulted in rapid improvement of clinical status, and no further vasopressors were required. Postoperative course was complicated by occlusion of the left iliac artery and an A.K. amputation on the left side was required.

A much more dangerous form of respiratory acidosis was seen occasionally after the correction of metabolic acidosis. These patients were characterized clinically by increasing respiratory rates and decreasing expansion of the thoracic cage leading ultimately to grossly inadequate ventilation and a rising partial pressure of carbon dioxide. Attempts to manage this with tracheostomy and Bennett respirator were only temporarily successful, and the long-term results were discouraging.

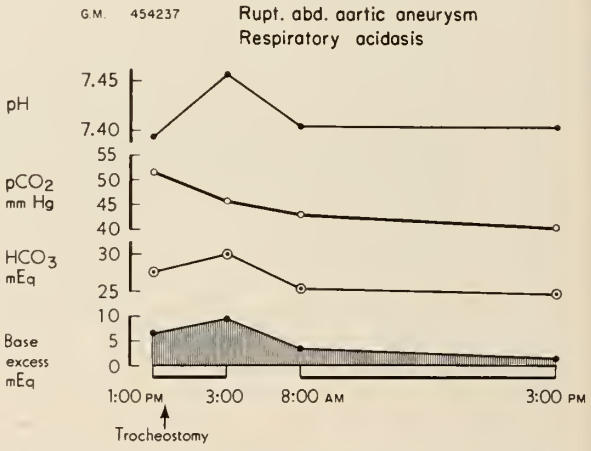


Fig. 5. Respiratory acidosis. Response to tracheostomy.

Respiratory Acidosis Developing After Correction of Metabolic Acidosis

Case 6.—J.D., No. 299296, a 67-year-old, Negro man, was admitted to the Receiving Hospital with a three-day history of mechanical small bowel obstruction. After partial correction of the fluid and electrolyte deficit, he was taken to the Operating Room and had lysis of adhesions. The patient tolerated the procedure well and was stable in the Recovery Room for three hours following the operation, but then rapidly developed severe hypotension and became confused and disoriented. The original acid-base determinations revealed severe metabolic acidosis (Fig. 6). The acidosis was readily corrected with sodium bicarbonate, and as this was corrected, the patient's clinical status improved markedly. He did well for approximately three hours when he became progressively hyperpneic and hypotension recurred. Studies at this time demonstrated severe respiratory acidosis. This acidosis responded only temporarily to tracheostomy and the

Bennett respirator, but the pressure required to ventilate the patient increased progressively, and he expired approximately 40 hours postoperatively. Permission for autopsy was not obtained.

with a decrease in PCO_2. Respiratory alkalosis of this nature has previously been described as occurring in septicemia especially with the gram negative bacilli.[12] It is thought to represent a central stimulation

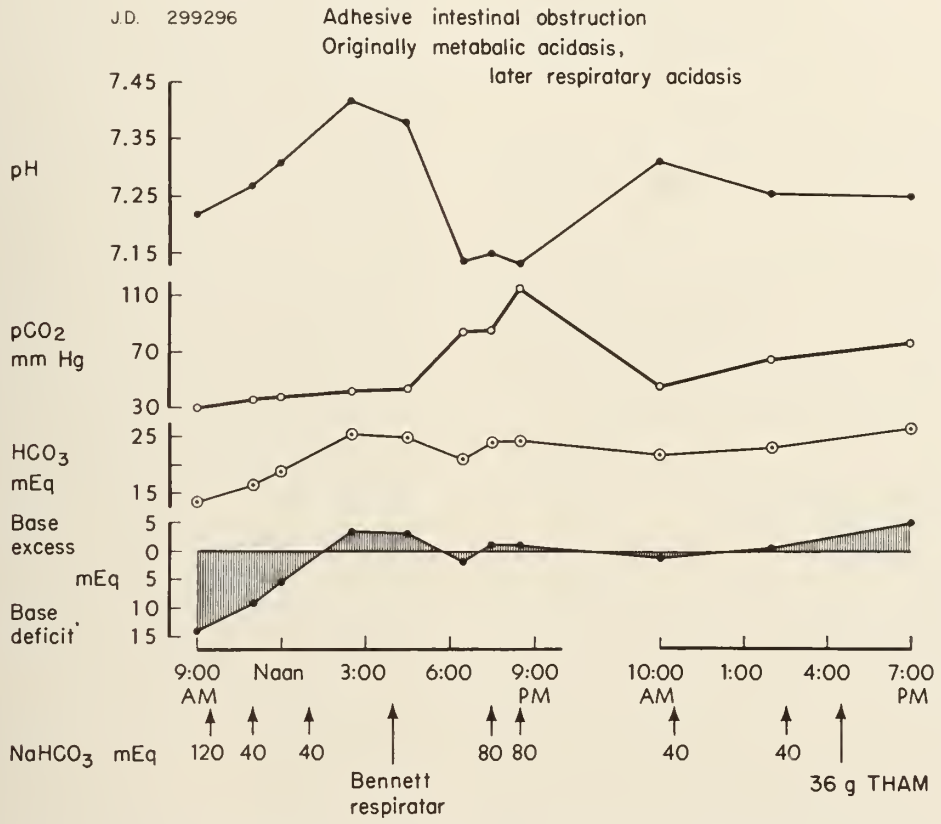


Fig. 6. Correction of metabolic acidosis followed by respiratory acidosis and terminal pulmonary failure.

The use of large amounts of sodium bicarbonate in the correction of metabolic acidosis demands the ability to eliminate the large amounts of carbonic acid formed. Patients with underlying pulmonary disease such as emphysema or fibrosis have great difficulty in handling this additional carbon dioxide load and rapidly develop severe respiratory acidosis. When placed on the respirator, the improvement is often only temporary and requires increasing pressure in ventilation. This in itself reduces cardiac output and aggravates the pulmonary damage. It seems likely that the use of THAM is indicated in this group of patients.

Respiratory Alkalosis in Shock

Respiratory alkalosis was encountered in three patients. These patients all had septicemia, clinically were hyperpneic, and appeared to be compensating for a metabolic acidosis, but studies showed an alkalosis perhaps due to endotoxin itself on the respiratory center. In our three cases no special treatment was required and the alkalosis subsided as the infection was brought under control. It is important to recognize that respiratory alkalosis may exist in septicemia, and that clinically this may mimic metabolic acidosis with compensatory hyperventilation. These patients should not be treated with sodium bicarbonate or THAM on the clinical assumption that the patient is acidotic.

Respiratory Alkalosis in Septicemia

Case 7.—D.W., No. 451713, a 13-year-old Negro girl, was admitted to the Receiving Hospital with marked dehydration and hypotension associated with ruptured appendix and generalized peritonitis. After replacement of fluid and electrolyte as well as whole blood, the patient was taken to the Operating Room where an appendectomy and thorough peritoneal lavage were performed. Postoperatively the patient was hypotensive and required Metaraminol to maintain the

blood pressure. She still had evidence of plasma volume deficit with hematocrit at 54 per cent, hemoglobin of 16.5, and was markedly hyperpneic and appeared to be compensating for metabolic acidosis. Original acid-base studies showed a respiratory alkalosis with a pH of 7.45, PCO_2 of 34 millimeters of mercury and a standard bicarbonate of 24. Plasma volume deficit was corrected with serum albumin, and septicemia treated with massive doses of antibiotics. As the clinical status improved, the acid-base values returned to normal.

Only one patient in the entire series presented with metabolic alkalosis, and this patient had a bleeding marginal ulcer following hemigastrectomy and vagotomy. The alkalosis was most likely related to the vomiting that the patient had in the postoperative period. It was believed that the vagotomy was inadequate in this patient. The bleeding was controlled with gastric hypothermia, blood volume was replaced, and the alkalosis easily corrected with saline. The patient went on to an uneventful recovery.

Discussion

Prompt recognition and treatment of blood volume deficits and fluid and electrolyte derangements has improved the management of hypotension. Nevertheless cases of severe illness are seen where the hypotension is refractory to ordinary measures. This is particularly true in the management of septic shock. Often these patients present a complex problem in combined cardiac, pulmonary and renal failure. Acidosis is a common finding and may be metabolic, respiratory or a combination of the two. As has been demonstrated in this paper, correction of the acidosis increases the sensitivity of the blood vessels to sympathicomimetic agents. Since the acidosis is a result and not a cause of the impaired peripheral circulation, it is imperative that correction of the acidosis be combined with attempts to improve cardiac output and peripheral perfusion. One of the most important and most readily correctable derangements are deficits of red cell mass or plasma volume. Our experience agrees with that of Smith and Moore that the "spot" blood volume measurements especially the use of RISA are difficult to interpret in shock, and in our hands, the central venous pressure is a more accurate index of volume replacement. If the patient remains hypotensive and the central venous pressure remains normal or low, further volume replacement is indicated. Acidosis with hypercapnea may cause cardiac arrhythmia and hypotension especially in the postanesthetic period.[14,15] This decrease in blood pressure cannot be explained on the basis of hypovolemia and is most likely related to the effect of acidosis on myocardial contractility or to release of potassium from the liver. Improvement in ventilatory efficiency will correct the defect, but terminal respiratory failure has been a common finding in our most seriously ill patients. Cases 2, 4 and 6 are typical examples of initial correction of blood volume deficit and acidosis associated with a marked clinical improvement to be followed shortly thereafter by clinical hypoxia, severe dyspnea, and a rising PCO_2. Initially, this can be managed by using the respirator to assist ventilation but terminally there is increasing resistance to ventilation. Finally even the respirator is unable to compensate for the decreased pulmonary compliance and the patients expire with respiratory acidosis and hypoxia. At autopsy these patients usually exhibit pulmonary edema, congestion and atelectasis. One patient (Case 2) had multiple pulmonary abscesses, while another had multiple pulmonary emboli. Many patients in this series had no specific underlying pulmonary disease yet terminal ventilatory failure was common. Possibly this reflects left heart failure as a result of shock. The importance of the vasoactive polypeptides in the causation of the pulmonary insufficiency needs further investigation. It has been shown that histamine, serotonin, epinephrine and endotoxin act on the smaller pulmonary veins causing increased resistance.[16] Elevations of various vasoactive polypeptides have been demonstrated in this laboratory, especially in septic shock.[17]

A consistent observation in patients with advanced septic shock has been the progressive development of cardiac, pulmonary and renal failure. When seen in this stage of the disease, all forms of therapy have been disappointing in our hands.

Conclusion

In the study of the acid-base derangements in refactory hypotension in man, acidosis is a common finding. This is usually metabolic in origin and can be corrected with sodium bicarbonate or THAM. THAM must be used with caution and facilities must be readily available to assist ventilation.

Respiratory acidosis may be handled with measures to increase ventilatory efficiency, but a terminal respiratory failure was a common mechanism of demise in these patients. The importance of the vasoactive polypeptides in this phenomenon are discussed. Respiratory alkalosis is occasionally encountered in patients with gram negative septicemia. This mimics an attempted compensation for metabolic acidosis and must be recognized and not treated as acidosis.

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Coming in April

The April issue of THE JOURNAL of the Michigan State Medical Society will feature an article on the psychiatric aspects of the practice of urology. Written by Dr. William Engel, formerly of the Cleveland Clinic, and now in retirement at La Jolla, California, the article introduces into the literature "Uropsychiatry" and contains information of interest to physicians in nearly every field of practice. A current report on the Michigan Maternal Tissue Registry will be presented by Dr. A. James French, M.D., and Isadore Selzer, director of the Michigan Cancer Registry, reports on the results of uterine cytologic examination of over 29,000 women reported to a cytology registry in metropolitan Detroit. An informative article by Dr. J. A. Penner helps keep us up to date on the laboratory and anti-coagulant therapy, and two unusual problems, human lysteriosis and neurilemmoma of the vagus nerve, will also be covered in articles in the April issue.

Physical fitness and frequent medical health evaluation is being stressed more in the medical and lay literature. Presuming that physicians are aware of the problems involved we attempted to evaluate the general physical status of our senior and junior medical staff. The most frequent and impressive abnormal finding was overweight. Some recommendations were suggested in order to increase the awareness of physical fitness among the physicians.

Physical Status of Interns And Resident Physicians at Wayne County General Hospital, 1962-63

Stanley Olejniczak, M.D., and Wayne W. Glas, M.D.,
Eloise, Michigan

IN VIEW of recent emphasis on programs of physical fitness, it was decided to evaluate the physical status of our medical staff. All of the junior and senior members of the medical staff were invited to participate in a program that consisted at first of physical examination and a set of physical exercises individually prescribed for each physician.

The participants in the program included 7 members of the senior medical staff and 32 resident physicians. Inasmuch as the number of examinees in the senior-staff group was too small to warrant drawing any conclusions, we decided to analyze the findings only in the group of interns and residents. It was interesting to note that no member of the relatively large staff of psychiatrists elected to participate in this program.

In the preliminary physical examination, the following findings were recorded for each examinee: height, weight, posture, mobility of spine, range of motion of the upper and lower extremities, and muscular strength (graded manually by the Brunstrom and Dennen method) in the major groups of muscles of the upper and lower extremities, and of the back and abdomen.

As a test of physical performance, we recorded the number of "chin-ups" that each physician could perform from a completely suspended position; this test involved complete extension of the elbows to an angle of 180 degrees, and raising of the body with the chin above the level of the bar. Another test of performance was that of "push-ups," with the body maintained in a rigid, fully-extended position during the period of the exercise.

After the physical findings were reviewed, the examiner instructed each individual to perform specific exercises in order to improve the posture or to increase the strength of the muscles in general or of selected groups of muscles.

The gymnasium in the Department of Physical Medicine was available to all participants in the program for use during the day. Initially, there was considerable enthusiasm for carrying out the exercises, but gradually the number of participants who continued to perform the exercises lessened, and only a

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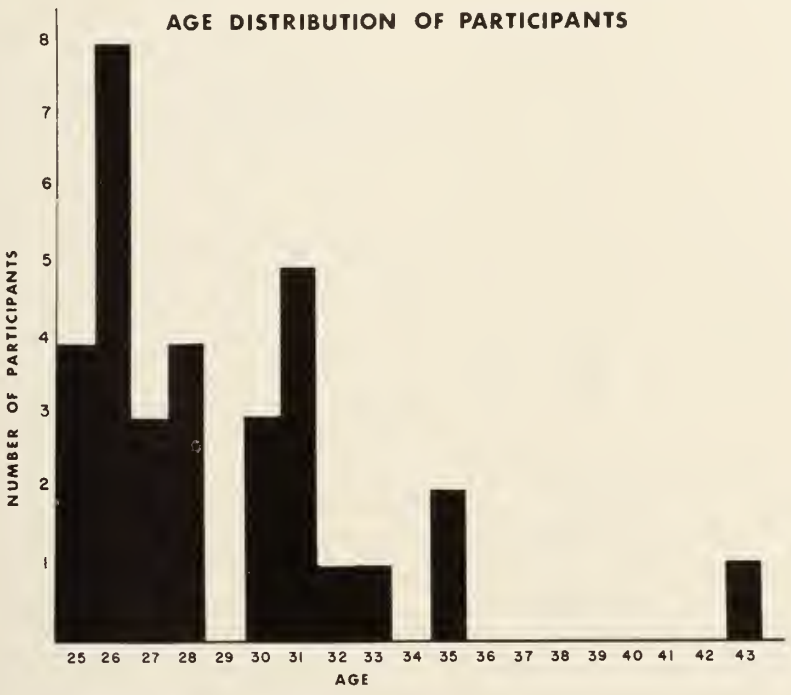


Fig. 1

few physicians persisted in their use of the gymnasium up to the end of their term of duty.

The ages of the 32 interns and residents, all male, ranged from 25 to 43 years.

The most frequent abnormal finding was overweight. Using as our standard, tables of "Average Weights of Adults," published by the Society of Actuaries (*Build and Blood Pressure Study*, volume 1, page 16, Chicago, 1959), 20 of the 32 (62.5 per cent) were overweight from 3 to 50 pounds (mean, 18.5 lb.; average, 19 lb.). A complete chart of weight distribution for the overweight group is shown in Figure 2.

In view of the relatively young ages of the physicians and their energetic activity, the percentage of those examined who were overweight is impressive. Answers to the question, "Why are you overweight?" included these two: (1) "Your chart is wrong," and (2) "The food is plentiful and good." The physicians who were overweight voluntarily stated that they would reduce. However, we believe that most of those who were overweight, in spite of the active nature of their work, would be likely to be overweight at the age of 40 or 50, at a period of life when their activities would be more stabilized, and their physical exertion decreased.

Fourteen of the physicians had a good posture, but in 18 the abdomen was protuberant; 13 manifested

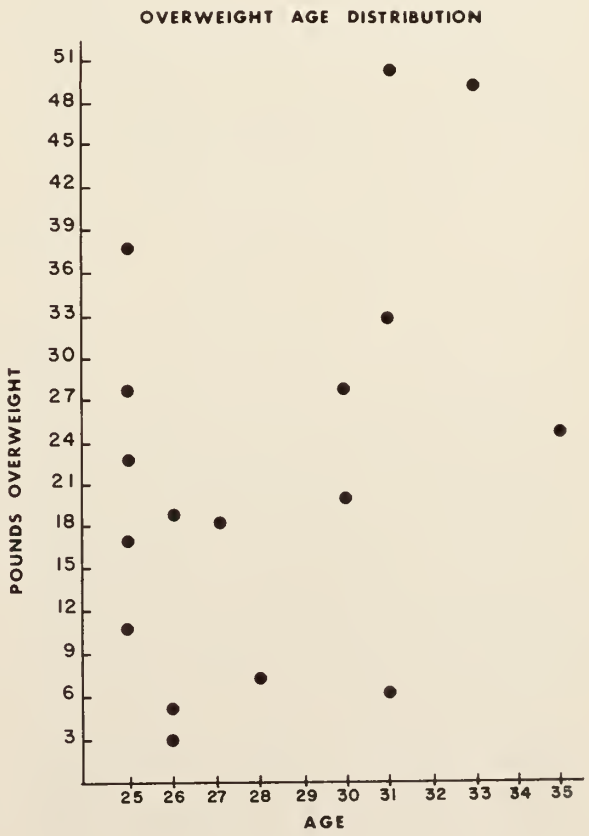


Fig. 2

some degree of kyphosis, and six some evidence of lordosis. Mobility of the spine was within normal limits in 22 persons. In 10, the lower region of the back was "tight," and the range of motion was considerably reduced. These persons were unable to touch the floor with the tips of their fingers while they were in a forward bending position (range, from 1.5 to 10 inches, with a mean of 5 inches, and an average of 4 inches). In all the participants, the range of motion of the shoulder joints was within the limits of normal. One physician had a genu recurvatum deformity bilaterally. There was some degree of tightness in the hamstring and hip flexor muscles in seven examinees.

The strength of the abdominal muscles was evaluated separately for the upper and lower groups of muscles. The strength of the upper group of muscles was regarded as "normal" in 30 persons and rated as "good" in two. The lower group of abdominal muscles was evaluated "normal" in four and "good" in 28. The strength of the erector spinae muscles was "normal" in all examinees. Nine physicians (28 per cent) complained of intermittent backache in the lower region of the back.

Physical performance was evaluated by means of "chin-up" and "push-up" exercises. The number of "chin-ups" that were performed ranged from one to 12 (average for the group, 4.5). The number of "push-ups" ranged from three to 32 (average for the group, 13). The average of the number of chin-ups performed by those who were not overweight was 6.5, whereas the average of the number performed by those who were overweight was 4.4. The average of the number of push-ups performed by those who were not overweight was 14.5, whereas the average of the number performed by those who were overweight was 12.1.

In view of these findings, it is interesting to reflect that most of these doctors had eating habits similar to those of nonphysicians, and that the percentage of examinees who were overweight is higher than would be expected among physicians. The high percentage of overweight physicians in this young age group is truly astonishing. As would be expected, the physical performance, with regard to the number of "chin-ups" and "push-ups" that could be performed, varies inversely with the degree of overweight. It would be of interest to determine the frequency and degree of excessive weight among interns and resident physicians in other hospitals in which food is not furnished free of charge.

In order to increase the awareness of physical fitness among physicians, we offer the following recommendations:

1. An annual physical evaluation should be made of all interns and residents and members of the permanent medical staff of all hospitals.

2. All physicians in the hospital should be encouraged to participate in a physical fitness program.

3. A program of physical fitness could be aided by cooperation with and suggestions from the department of physical medicine of the hospital.

Heart Study

There appears to be no need for restricting ordinary activities and pleasures of life in order to avoid death from coronary thrombosis. Environmental factors apparently have little or no effect. This is the conclusion reported by Dr. Arnold Brown, County Medical Officer of Health, Cheshire, England. Medical histories and environmental particulars of 536 men and women who had died aged 45 to 65 years from coronary thrombosis were compared with similar information from 642 controls of the same sex and age groups.

"There was no evidence to establish that family circumstances, holidays, consumption of fat, alcohol, or tea, times of meals or of rising or going to bed, participation in sports or games, visits to club or hotel, employment (in the case of women), addiction to radio or television, overtime or night working, and whether the job was manual or not, heavy or light, affect the liklihood of death from coronary thrombosis," Dr. Brown said.

A significantly higher proportion of controls gave gardening as one of their two principal leisure activities. Walking also was more popular among controls, and in the case of women significantly so. "Work involving walking, and gardening in leisure, lessened liability to death from coronary thrombosis," Dr. Brown continued.

Abstention from or consumption of alcohol made no difference. To enjoy highly seasoned food, to take extra salt or condiments, or to be a "hearty eater" did not affect the percentages. There were, however, significantly fewer deaths among coffee drinkers.

Injuries Of Industrial Significance

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DURING the first half of the present century surgery in industry progressed from a medical department consisting of a few unsterile bandages in a cigar box to the fully equipped, well staffed department of the modern industrial plant.

Industry profited by the experience of World War I. In the first year of that war the mortality in open fractures was 85 per cent. Due to the discovery of four factors, mortality had been reduced to 15 per cent by the end of the war. These factors were: I Requiring corps men to administer morphine at the site of injury to control pain and shock, II The heating of ambulances by placing the exhaust pipe up through the body of the vehicle, III The use of the Thomas Splint to provide traction during transportation, and IV The development of surgical teams, composed of young surgeons, which could be rapidly dispatched to the combat area, thus providing early surgical care. By World War II, improved methods of transportation by air lift were added, placing the severely injured in the Base Hospital within a short time.

American industry quickly adopted these techniques in handling the increased load of industrial casualties resulting from the need for increased production to meet the needs of the military forces.

The industrial surgeon, being closely associated with the chemists, physicists and toxicologists, recognized the importance not only of the environment, and of the local trauma, but also the condition of the "whole man" and gave consideration to the more important reaction of the injured employee to the stress.

Employees who had received pre-employment examinations and periodic check-ups, were more easily evaluated at time of injury and efficient treatment promptly instituted.

As industrialization in America proceeded at a faster and faster pace during and after World War II, trauma became as important on the home front as it was on the battlefield. At the time, a major portion of the literature dealing with surgery was devoted to consideration of the specific physical changes resulting from disease or trauma. Gradually, there developed an appreciation of the importance of physiological changes and a realization that to secure the best end results, or to assure recovery, attention must be focused on the response of an injured employee to the stresses involved. Since this response or lack of response is based upon the degree of *shock* produced by the trauma, there followed an upsurge of both medical and surgical research into the nature, the effects and the treatment of shock.

If we go from the multiplicity of causes of shock, to the behavior of the organism, we find that certain patterns of response to stress constantly recur. To understand this fact we must turn to a basic concept in biology first introduced by Claude Bernard in 1878: "All the vital mechanisms, however varied they may be, have only one object, that of preserving constant conditions of life in the internal environment." (Mileau interieur)

The importance of this concept lies in the fact that it provides the foundation for our understanding of the response of living organisms to various types of stresses—for it is logical to assume that since the character of the internal environment is relatively constant, the pattern of response to stress must also be uniform.

Cannon, in 1923, extended Bernard's work by analyzing the mechanism by which the body main-

From the Department of Surgery, Alexander Blain Hospital.
Presented at the Annual Meeting of the Michigan State Medical Society, Detroit, September 27, 1962.

tains the constancy of the fluid internal environment. He pointed out that this state of equilibrium was preserved by the integrated cooperative function of many organs, including the nervous system, heart, lungs, kidneys, spleen and liver.

If we analyze the various forms of stress such as trauma and hemorrhage, it becomes apparent that when they are mild they will cause little or no disturbance of the internal environment, but when sufficiently severe will cause injury to the organism. This damage may extend to the point of impairment of cellular nutrition, particularly in relation to oxygen —and the final result of all forms of stress, if severe enough, will be anoxia of varying degree.

The symptom complex we call *shock* may have many origins leading to a fundamental circulatory failure characterized by a disparity between the circulating blood volume and the capacity of the vascular bed. While it was formerly thought that vaso-constriction in the early stages of shock tended to compensate for decrease in blood volume and cardiac output, it was found that total peripheral resistance was increased only moderately in early shock, and was never maximal. It was probable that generalized arteriolar vaso-constriction had only a negligible effect in sustaining arterial pressure, and that the constriction was a net *unfavorable* influence because it decreased blood flow to vital organs.

Observation of the behavior of these structures revealed two phases of the development of shock—first, an initial *compensatory* phase characterized by the shunting of blood away from the capillary bed back into the venous system by the pre-capillary sphincters; and a *decompensatory* phase characterized by progressive hyporeactivity of the terminal vascular bed, with pooling of blood in the capillaries. This latter stage is identified with irreversible shock.

These same studies develop a new concept of hemodynamic mechanisms involved in shock based upon the demonstration of specific hormonal principles which control the reactivity of the terminal vascular bed.

The production of these substances is related to hypoxia of specific tissues; VEM (vasoexcitatory material) being released by the kidneys, and VDM (vasodepressor material) chiefly by the liver, but also by the spleen and skeletal muscles. VEM is thought to be largely responsible for the action of the precapillary sphincters during the compensatory stage. The liver has the ability to inactivate VDM accumulation in the blood stream—but the loss of this ability through liver damage is responsible for the phenomena associated with the hyporeactive stage, and ultimately with irreversibility.

Fine, in his investigations of the effect of bacterial infections in the development and aggravation of shock, also works on the premise that traumatic shock is a state of acute and persistent deficiency of blood flow through the peripheral circulation, which, if sufficiently severe and untreated, grows progressively worse and is rapidly fatal.

Recognizing the importance of the physiological reaction to traumatic stresses, utilizing his ability to evaluate the disturbance in haemodynamics presented by the injury and making full use of the therapeutic measures which have been developed, the industrial surgeon can carry out procedures which result in great improvement in types of injury which formerly resulted in high mortality or prolonged disability.

For example, crushing injuries of the pelvis which destroy the blood supply to a lower extremity are now treated by inter-innomino-amputation. A portion of the iliac crest is retained to provide a shelf which permits fitting of a prosthesis and thus a return to wage earning.

Another example is the immediate excision of tissue destroyed by thermal or electric heat and skin grafting before the expiration of a forty-eight-hour deadline, before secondary infection and toxic effect sets in. This results in a shortening of disability, and great improvement in the functional results obtained.

A better understanding of the blood supply to the os calcis has permitted open reduction and correction of even the most severely crushed deformities of that bone, the repositioning being maintained by internal fixation. The period of disability in the industrial worker was formerly two years, the present methods shorten this period to three months and greatly reduce the percentage of partial permanent disability.

In conclusion, with the assistance of a shock team, a competent anesthetist, laboratory support and the use of adequate whole blood, the industrial surgeon can carry out major procedures which formerly were impossible.

This results in the objective of surgery in industry being attained, that is, the return of the injured employee to work with the greatest attainable skill in the shortest possible time.

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Spontaneous Pneumothorax in the Newborn Following Routine Cesarean Section

Spontaneous pneumothorax is a serious but seldom considered complication of the newborn calling for early recognition and immediate treatment. The literature is reviewed and three cases of this condition following cesarean section are presented.

Carl F. Shelton, M.D. and Robert C. Marvin, M.D.
Detroit, Michigan

ONE of the most serious complications which can develop in the immediate newborn period is that of unrecognized spontaneous pneumothorax.

Early recognition and appropriate treatment of spontaneous pneumothorax are two of the most important factors in increasing neonatal survival. To emphasize the importance of considering the possibility of this condition in those newborn infants with respiratory difficulties, three interesting cases following cesarean section are reported.

Spontaneous pneumothorax is the term used to indicate the presence of air in the pleural space, as demonstrated by roentgenogram or autopsy performed.

Tension pneumothorax demonstrates contralateral shift of the mediastinum, widening of the intercostal spaces, and depression of the diaphragm as diagnosed by roentgenogram[3] and by release of gas under pressure from thoracentesis.

Spontaneous pneumothorax in the newborn varies from 0.07 per cent to 37.5 per cent, depending on the investigators.

In 1930, Davis and Stephen[1] detected six cases among 702 consecutive newborn infants by routine chest films, and their 1 per cent figure is still widely quoted in pediatric textbooks. Harris and Steinberg in 1954[2] reported an 0.07 per cent incidence of spontaneous pneumothorax which approximates the findings of Davis and Stephen in 1930.[1]

Air is found with some frequency in the interstitial, interlobular, and subpleural portions of the lungs and in the thorax or mediastinum. In a living infant, pneumothorax should always be considered in the differential diagnosis of dyspnea.

Pneumothorax may produce severe dyspnea and may interfere sufficiently with respiration to cause death. If the condition is recognized and the air removed, recovery is usually dramatically prompt. Mild pneumothorax is probably much more common than is generally recognized and often is asymptomatic. With unilateral pneumothorax, air is usually present in the interstitial tissues of the lung on the opposite side, and the pneumothorax is produced by the entrance of air from the opposite lung via the mediastinum.[6]

According to the Macklins,[5] air enters the sheaths of the blood vessels as a result of the establishment of an abnormal pressure gradient caused by (1) overinjection of alveoli without corresponding expansion of vascular lumens with which the alveolar walls are in contact, or (2) reduction of vascular lumens without a corresponding decrease in the lumen of the alveoli to which they are attached. The second factor rarely, if ever, operates in the newborn.

In the histories of all but rare cases of interstitial emphysema and pneumothorax in the newborn, artificial resuscitation has been attempted. When respiration is claimed to have been spontaneous and unaided by mechanical means, one can only suppose that the infant's attempts to overcome an obstruction in its bronchi or trachea raised the intra-alveolar pressure sufficiently to cause rupture of the walls. Air may enter the thoracic cavity on the involved side if the rupture extends through the pleura, or it may escape

From the Department of Obstetrics and Gynecology' Woman's Hospital, Detroit, Michigan.

into the opposite side via the sheaths of the blood vessels and the mediastinum.

The pneumothorax that results from rupture of the alveoli directly into the pleural space, or from rupture of an air cyst, is no greater than that which can be produced by the elimination of negative pressures in the pleural cavity. The air enters the pleura under atmospheric pressure and, unless complicating factors are present, the air in the pleural space will remain under this pressure.

Tension pneumothorax is evidenced when pressure is greater than that of the normally inspired air. It is questionable whether it ever occurs in the newborn, except as a result of artificial resuscitation. The diagnosis of tension pneumothorax can be made by the x-ray findings of a diaphragm which has ballooned out and which presents a flat or convex surface toward the abdomen.

In the living infant, pneumomediastinum is best diagnosed from lateral x-ray projections of the chest. Pneumothorax is best diagnosed from an antero-posterior view. The clinical manifestations; namely, dyspnea, cyanosis, distant heart sounds, distended neck veins, should alert one to the possibility of a pneumothorax, and confirmatory x-rays should be taken.[7]

Causes of spontaneous pneumothorax

(a) disease of the lung by pneumonia
(b) congenital defects, i.e. blebs
(c) traumatic injuries
(d) forceful external resuscitation
(e) mechanical obstruction
(f) idiopathic

Prevention

(a) avoidance of traumatic deliveries
(b) gentle aspiration of oral pharynx and nasopharynx prior to spontaneous respiration
(c) immediate diagnosis and correction, if possible, of any respiratory obstruction[4]

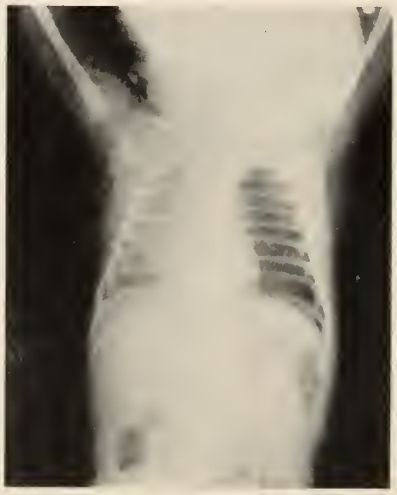


Fig. 1. Case 2. Postero-anterior view, September 8, 1962, untreated.



Fig. 2. Case 2. Lateral view, Septemper 8, 1962, untreated.

Treatment

Air in the pleural space is unphysiologic, but can be absorbed without aspiration if there is no continuing pleural leakage. With evidence of increasing or tension pneumothorax in a newborn, thoracentesis and continuous drainage by way of an underwater trap should be done. Aspiration of the pleural cavity can not be expected to have an effect on pulmonary interstitial emphysema, hyaline membrane disease, or aspiration pneumonia, if these conditions constitute the primary pathology.

Three cases of spontaneous pneumothorax in the newborn following cesarean section are reported:

Case 1.—Mrs. S.W., age 42 years, gravida ii, para i, was admitted to the hospital June 7, 1960 for a repeat cesarean section. She previously had a cesarean section for toxemia in 1955. The physical examination was essentially negative, except for a blood pressure of 160/100 and pretibial edema. The patient was of about 38 weeks gestational size, with the FHT 140 and regular. On June 8, 1960 a repeat cesarean section was performed under spinal anesthesia, and a 6 pound 2 ounce boy was delivered. The baby was slow to cry, and a bulb aspiration was used. The delivery was easy and non-traumatic.

On June 8, at 8:00 P.M., it was observed that the child was grunty, and he was placed in oxygen. Later that night an emergency x-ray was taken which revealed a 30 to 40



Fig. 3. Case 3. Postero-anterior view, September 11, 1962, untreated.



Fig. 4. Case 3. Lateral view, September 11, 1962, untreated.



Fig. 5. Case 3. Postero-anterior view, September 13, 1962, under treatment.



Fig. 6. Case 3. Lateral view, September 13, 1962, during treatment.



Fig. 7. Case 3. Postero-anterior view, September 17, 1962, after treatment.



Fig. 8. Case 3. Lateral view September 17, 1962, after treatment.

per cent collapse of the left lung. The right lung was clear. The child was transferred to Children's Hospital. On June 9, a repeat radiograph revealed a small left pneumothorax and focal atelectasis; on June 10, a radiograph showed that the pneumothorax had almost cleared; and on June 13 x-ray revealed a normal newborn chest. The child was treated conservatively and was discharged June 15, 1962 as asymptomatic.

Case 2.—Mrs. J.M., aged 33, gravida vii, para v, ab. i, E.D.C. September 7, 1962 was admitted for a repeat cesarean section. Her physical examination revealed essentially negative findings. Her blood pressure was 110/75. On September 7, 1962, cesarean section resulted in an atraumatic delivery of an 8 pound 10 ounce boy. The baby had a spontaneous cry and was of a good color. Bulb aspiration of the oral and nasopharynx was performed immediately after delivery, and the stomach was aspirated by the anesthesiologist. In the evening of September 7, 1962, it was noticed that the baby had developed shallow respiration and he was placed in oxygen. The shallow respiration continued on September 8, and it was noted that when he was taken out of oxygen his color was very poor. A chest radiograph revealed a massive left pneumothorax with right atelectasis. On September 8, at 3:00 P.M., he was pronounced dead. The pathology report revealed (1) congenital blebs left lung, lower lobe, (2) left spontaneous pneumothorax, and (3) atelectasis both lungs. Microscopic examination showed bilateral hyaline membrane disease.

Case 3.—Mrs. A.O., 30 years old, gravida iv, para iii, was delivered of a 7 pound baby by a vertical cesarean section under spinal anesthesia. The baby had a spontaneous lusty cry and appeared to be in satisfactory condition. Immediately after delivery the oral nasal pharynx was aspirated with a rubber bulb, and the stomach was aspirated with a soft catheter. On September 10, 1962 at 5:30 P.M., it was noted that the baby had developed labored respirations and turned pale when quiet. It improved when placed in oxygen. A chest radiograph taken on September 11 revealed left pneumothorax with massive displacement of the heart and mediastinum to the right. The pneumothorax was immediately treated by the use of a chest tube inserted by a closed thoracotomy. On September 17, 1962, a repeat radiograph showed a disappearance of the pneumothorax, and on September 18 the chest x-ray was normal.

Summary of Cases Presented

1. Three cases of spontaneous pneumothorax in the newborn following repeat cesarean sections at Woman's Hospital, Detroit, Michigan, are presented.
2. Of the three babies, one expired.

Conclusion

1. Spontaneous pneumothorax is a serious complication in the newborn.
2. Early diagnosis is essential as is prompt treatment.
3. All newborn infants with dyspnea and other signs of cardio-respiratory difficulty warrant immediate x-ray examination of the chest.
4. In the three cases presented, vigorous resuscitation was not necessary. In the infant that expired, autopsy showed congenital blebs and hyaline membrane disease.
5. In infants who show severe cardio-respiratory symptoms secondary to spontaneous pneumothorax, immediate thoracentesis is the treatment of choice.

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Doctor-Population Ratio Improves

The ratio of doctors to population is increasing sharply, latest AMA figures reveal. W. Clarke Wescoe, M.D., Chairman of the Council on Medical Education and Hospitals, reports there are now 146.7 physicians for every 100,000 Americans, a gain of 8.9 physicians over the 1960 figures and 11.4 over 1950.

The number of first-year medical students rose from 7,177 in 1950 to 8,928 in 1960, he notes, while the number of medical graduates rose from 6,135 in 1950 to 6,994 in 1960 and by 1963 had risen to 7,324.

The 1963 ratio, says Dr. Wescoe, is based on a physician population of 275,974 and a total U. S. population of 188,000,000 . . . "Based on the number of licentiates, minus the number of deaths, the physician population increased by 4,500 last year," he explains. "In 1950, the increase was only 2,208—If the present yearly increase continues, we shall have 307,500 doctors in 1970."

Excision of Carotid Body For Advanced Emphysema

The treatment of advanced pulmonary emphysema has been most unsatisfactory to date. Its physiology and pathology are just as poorly understood. Recently Overholt and Nakayama have shown great symptomatic relief of shortness of breath in such victims by Carotid Body Excision. This report represents study and results of 39 consecutive cases. It compares favorably with the 85 per cent improvement rate of Overholt's series. The need for clarification of the word "asthma" is stressed as this procedure is found to work best in patients other than victims of pure bronchial asthma.

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IT IS a sad experience for all physicians when confronted with a medical problem for which there is as yet no satisfactory treatment. The leaps and bounds of advance made in many facets of medicine are made all the more conspicuous by the few that remain unprogressed. Advanced pulmonary emphysema with all its diverse ramifications stands out prominently among this group. With the increase in longevity it seems there is also an increase in incidence of this disease in the last two decades.

Treatment for this malady leaves much to be desired, notwithstanding the fact that even full understanding of the basic sciences of this disease is lacking. There is still a nebulous area regarding the physiology and pathology of pulmonary emphysema despite the many symposiums organized by learned groups on this problem. In addition semantic difficulty further complicates any actual communication between researchers on this problem. The word "asthma" especially typifies this difficulty as it conveys different connotations to different persons. While actual improvement in the knowledge of this problem will be left to the future and to basic research, pursuit of symptomatic relief is a responsibility of all. This paper is a report of experience with 39 desperately dyspneic patients who were treated with cervical glomectomy in the last two years. These have all had intensive treatment for this malady, such as elimination of infection and allergic factors, hyposensitization, decongestion, bronchodilators, steroids, aerosol treatment, IPPB*, and even change of environment. Most of them have been repeatedly hospitalized for acute episode of pulmonary insufficiency.

Following the rationale that this is a resection of a chemo receptor sensitive to blood O_2, CO_2 and pH level and thus breaking a reflex cycle that has become harmful to the host because of pathological condition of the lung, cases were selected primarily among persons with advanced emphysema rather than purely allergic asthmatic patients. These patients range from 40 years of age to a high of 75 with an average of 59 years of age, 35 male and 4 female. The lowest maximum breathing capacity was 19 per cent of predicted normal as preoperative reading and highest was 57 per cent of normal.

Postoperative readings gave a maximum improvement of doubling the preoperative level to about 15 per cent increase. Clinically, seven patients were operated on in Semi Fowler's position under nasal

*Intermittent positive pressure breathing.

oxygen. Four patients had no appreciable increase in their "wind." Two had no improvement at all. All express the increase in depth of their breath and ease to "draw air in." Twenty-five could walk two blocks and were no longer house-confined. Three were even able to play golf. The results are therefore most gratifying except for the six patients mentioned above. Out of these six patients, two were female. All six have high allergic factors, all were on cortisone and allergic to almost all things tested. There was no operative morbidity nor mortality.

	Maximum Breathing Capacity		Timed Vital Capacity	
	PreOp.	PostOp.	PreOp.	PostOp.
WT.	20.7	41	55.5	66.5
HM.	43.9	53	43.9	60
EF.	34	43	34	86
RD.	57	71	59	74

Comment

It is gathered from the study of this series of cases that:

1. This procedure is well tolerated by patients who are obviously desperately ill and

2. This procedure can be carried out under local infiltration anesthesia with a minimum of risk.

3. This procedure has a definite place in the management of acutely distressed patients with advanced emphysema.

4. This procedure has a dubious value in patients with allergic asthma. This seems to be in accord with the known physiology of the carotid body.

5. A need exists in being able to determine how large a part allergy plays in any specific patient so as to enable better selection of patients for this procedure.

6. In lieu of definitive treatment cervical glomectomy renders appreciable symptomatic relief to otherwise suffering and emphysematous patients.

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AMA Report on Driver Licensing

The AMA Committee on Medical Aspects of Automotive Safety has been considering for some time the problem of developing medical criteria for the licensing of drivers.

The American Medical Association believes that physicians must assume leadership in the development of sound medical criteria for driver licensing. The diagnosis of medical conditions affecting the ability of an individual to operate a motor vehicle is the responsibility solely of the physician.

The AMA believes that the recognition and appropriate handling of "driver limitation" will contribute markedly to automobile accident prevention programs. "Driver limitation" as used in this statement is defined as a condition or state due to physical and/or mental factors which result in impairment of the ability to operate a motor vehicle safely.

It is recommended by the AMA that a medical examination for "driver limitation" be conducted at least under the following conditions:

1. When a license applicant displays an obviously impaired physical function.

2. When a driver has been involved in multiple accidents within a short calendar period.

3. When a driver must be placed in the "assigned risk" pool for insurance underwriting because of refusal by various commercial insurance carriers to assume the risk.

4. When a driver voluntarily suggests that he "blacked out" or that medical problems contributed to an accident.

Emotional Illness And the General Practitioner

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MANY years ago, practically all physicians were general practitioners and treated nearly all ill patients including those with emotional disturbances. More recently, many physicians have restricted their work to some branch of the practice of medicine. Those who devoted time and attention to emotionally disturbed patients became proficient in understanding them and hence managed them better. General practitioners have been grateful to be able to refer patients to them.

Life in today's social world has been described recently by Jimmy Hoffa as "a brutal jungle." Jimmy Hoffa is not a professional philosopher but Norman Cousins, editor of *Saturday Review*, has referred to him as "a systematic thinker who knows his way around in the jungle." The uncertainties of contemporary social life foster insecurity, tension, anxiety, fear, and discord. More patients need counseling than psychiatrists can accommodate effectively. Perhaps we have come full cycle. Perhaps the situation calls for general practitioners assuming a more active role in diagnosis and treatment of troubled patients particularly those with less severe disturbances, phobias, anxiety, melancholia, and destructive impulses.

Some persons find life a little strenuous in Mr. Hoffa's jungle. Family members may have lack of understanding, conflicting interests, and work at cross purposes resulting in stressful social and emotional situations. The family physician is the most natural and the most readily accessible person to consult on these occasions. Quelling emotional storms falls readily within the purview of general practitioners. It takes a good deal of training, experience, and common sense to be a capable family doctor. Early and continued training of medical students toward a better understanding of patients in general and their emotional lives in particular would be a great asset in general practice.

Numerous physicians not in general practice have said, "The general practitioner is the backbone of the practice of medicine." More is needed than a strong backbone and good intentions to manage patients with aggravated mental and sociopathologic problems. Time, patience, and persistence are needed. However, care must be given, and general practitioners will find satisfactions in giving aid to those who need it. Psychiatrists are rendering noble service in formal teaching and informal discussions with interested general practitioners. This phase must be continued and extended; otherwise, many responsibilities in emotional and mental disturbances will go by default to non-medical agencies.

The close personal relations of the general practitioner with patients and their families over long periods usually give him the first opportunity to see a patient with a psychosis. This experience will help the physician recognize that some degree of psychologic disturbance often accompanies a long recital of vague physical complaints, "a welter of misleading symptoms."

The physician must be cautious not to belittle the patient's complaints and not to send him away by saying, "There is nothing wrong."

Disturbed patients are unhappy, sensitive, and apprehensive. A curt dismissal will make them more withdrawn and uncommunicative. The physician must be endowed with an uncritical attitude, inexhaustible patience, and empathy. The patient does not reveal immediately the prime cause of his discontent. Indeed, he may not be aware of it. Later, under continued favorable circumstances, with gentle questioning and adroit channeling of discussion, both physician and patient may uncover one or more of the underlying irritating factors.

Many persons are disturbed by the gyrations of contemporary world politics, the timid are bewildered, the neurotic are terrified. Fear of the country blundering into war, fear of atomic warfare, fear of unemployment and other financial crises are frightening

many apprehensive persons. Self-rising patriots for profit are terrifying susceptible citizens with innuendoes, hoaxes, and downright untruths about our political and economic climate. Some persons imbued with intolerance and hate now believe they enjoy public sanction. Those with aggressions feel they can display conduct society would reject in other times. Argument and reason will not prevail over fear. It will take considerable patience, wisdom, leadership and, above all, education.

Physicians have long been aware of emotional illness in patients with various psychoneurotic complaints; depression; agitation; alcoholism; inability to get along with family, friends, neighbors, or the police; and the so-called psychopathic personality which may combine many of these symptoms.

Depression is encountered very frequently and can be deceptive and disruptive. It often results in loss of interest in life, friends, food, and appearance, with pessimistic outlook about the future. More serious depression presents distorted complaints not in accord with reality about accomplishments, position, or finances. Sometimes, there are veiled threats about divorce, suicide, or homicide. Depression may take on a psychosomatic mask in so-called migraine, hypertension, pylorospasm, gastric hyperacidity, spastic colitis, and various allergic phenomena such as atopic dermatitis, urticaria, asthma, and arthritis. Sometimes, these disturbances present difficulties in determining prime irritants. Frequently, the physician may need to discuss the problem with other members of the patient's family.

Emotional disturbances are outer manifestations of inner conflict.

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Scientific Sessions Taking Shape for AMA Meeting in June

The AMA Council on Scientific Assembly will offer an outstanding Scientific program for the 113th annual meeting in San Francisco June 21-25.

J. Arnold Bargen, M.D., Temple, Texas, Chairman of the Council on Scientific Assembly, reports "The combined efforts of many people, particularly the Section Secretaries, have helped to formulate a program that will be an outstanding contribution to graduate medical education."

John Hickam, M.D., Indianapolis, Chairman of the Program Planning Committee of The Council, stated that the following general scientific meetings have already been coordinated by section secretaries:

"Differential Diagnosis of the Liver and Pancreas," "Hyperbaric Oxygen Phenomena," "Computers in Medicine," "Autoimmune Mechanisms and Disease," "Cardiovascular Opacification," and "Tumors of the Endocrine Function."

In addition, a special half-day program on various aspects of heart disease will be offered by the American College of Cardiology and the American Heart Association.

The popular and interesting Research Forum program, under the chairmanship of Edwin Ellison, M.D., Milwaukee, will offer 60 papers, based on original work being done in the nation's medical schools.

A general scientific meeting program that has already elicited considerable interest is the half-day session on "Hyperbaric Oxygen Phenomena."

Premarital Examination Law

By Albert E. Heustis, M.D.
State Commissioner of Health

Some months ago, considerable publicity was given to Michigan's premarital examination law as a result of alleged irregularities by several laboratories. One of these involved the signing of the medical certificate by a physician. It is perhaps timely then to review our legal responsibility as physicians empowered to certify as to the absence of venereal disease.

The law itself, Act 207, passed in 1937, states in part: "All persons making application for license to marry shall at any time within 30 days prior to such application be examined as to the existence or non-existence in such person of any syphilis, gonorrhea, or chancroid . . ." It is clear that the law requires certain minimum things to be done by a physician before he places his signature on a medical certificate. Certainly no physician can in good conscience certify as to the absence of venereal disease unless he has carried out the essentials of a good medical examination.

Recently, the state health department set forth its opinion of what should be the minimum content of such an examination. In addition to an approved serological test for syphilis, the department says that such an examination should consist of the following:

Syphilis: Physical examination for the presence or absence of skin or mucous membrane lesions.

Gonorrhea: (1) The examination of the genital tracts of both the male and female for clinical evidence of gonorrhea.
(2) If clinical evidence is present, a specimen shall be submitted to an approved laboratory for examination.

Chancroid: Examination of the genitalia and anus for the possible presence of chancroidal lesions. If such lesions are suspected, smears shall be taken and submitted to an approved laboratory to determine the presence or absence of the Ducrey bacillus.

Unquestionably, to perform even such a minimum ex-

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amination may require substantial time and may compel some physicians to charge a higher fee than otherwise. But the law is clear. As physicians, we have always championed freedom of the individual and we have opposed unwarranted interference between the physician and his patient. But we must recognize that our right to freedom carries with it an obligation. If we fail in meeting our responsibility, if any of us knowingly signs a medical certificate on the basis of a serological test only, then interference will be warranted and we will deserve some loss of our freedom.

Small Plants and the Part-Time Physician

By The Occupational Health Committee, MSMS

As we drive about Michigan and see its many factories, most of us are apt to conclude that large plants characterize our industrial landscape. The fact is that Michigan differs little from other states in that most of its business establishments are small. Of the more than 127,000 business establishments reporting taxable payrolls under the Social Security Act, only 2000 employed a hundred or more persons. The provision of Occupational Health Services to the thousands of employees in these small plants presents formidable problems to the managers and countless opportunities to the physicians in practice.

It is clear that such small businesses cannot afford the full-time services of a physician, nor would the work to be done keep a physician fully occupied. If medical assistance is to be found, it must come from the physician in practice who is willing to devote a portion of his time to what can be a most rewarding type of experience. The opportunity to engage in some part-time industrial work is frequently attractive to the younger physician starting his practice in the community.

Today's physician possesses the basic skills required for such service, but he would be well advised to recognize that good industrial medical practice involves activities that are sometimes unfamiliar to him. Rather than acquiring these additional skills by trial and error, he will save time and avoid frustration by consulting industrial physicians and drawing on the well-documented experience of others through reading and study. The March, 1963, issue of the *Journal of Occupational Medicine* contains a bibliography of some of the more important reference materials in the field. Some evenings spent reading selections from this list will provide a helpful introduction to the problems unique to occupational medicine.

It is not always easy for management to find physicians prepared to undertake part-time work, nor is it easy for the physician to identify those plants that might be interested in employing his services. Where they exist, the occupational medicine committees of the County Medical Societies can be of assistance. On a state-wide basis, the Michigan Industrial Medical Association is cooperating with the Michigan Health Council in serving as a clearing house for management and the medical profession alike. Physicians interested in such work are urged to make their interests known to the above groups.

Questions and Answers About Woman's Auxiliary

By Mrs. R. J. Himmelberger, President, Woman's Auxiliary To Michigan State Medical Society

Q. *What is the Woman's Auxiliary to the Michigan State Medical Society?*

A. The Auxiliary is an organization of physicians' wives, dedicated to promoting better health.

Q. *What is the purpose of the Auxiliary?*

A. The Auxiliary assists the Medical Society through its members to explain the ob-

jectives of the medical profession to lay organizations interested in health education—to assist in the entertainment at all Michigan State Conventions—to promote acquaintanceship among physicians' families and thus foster better fellowship—to do such work approved or assigned by the Michigan State Medical Society.

Q. *How many members does it have?*

A. About 3,200 physicians' wives, only about half of its potential membership.

Q. *How is the Auxiliary organized?*

A. Our organization is divided into Districts and each District is made up of a number of County Auxiliaries arranged on the same basis as the Michigan State Medical Society.

Q. *Does the Auxiliary have any current projects?*

A. Yes. The Auxiliary stresses community service activities and all of the County Auxiliaries conduct some type of community service program covering a wide range from civil defense, mental health, rural health, home and highway safety, medical quackery, plus recruitment of outstanding young people for health and medical careers and raising funds for medical scholarships and schools.

Q. *You mentioned raising funds for medical schools and scholarships. Can you tell us more about this particular Auxiliary project?*

A. This is one area in which the Auxiliary has worked especially hard. Last year doctors' wives raised $16,559.40 in Michigan for medical schools and a medical student guarantee loan fund.

Q. *What about the Auxiliary's work in recruiting young people for medical careers?*

A. Auxiliary groups sponsor Future Nurses Clubs—planning teas and educational programs in high schools to encourage girls to enter the nursing field. Many of the local Auxiliaries also offer nursing scholarships and loans for nursing education. And in recent years we have also encouraged young people to enter other related health fields—medical technology, occupational therapy, physical therapy and so forth. Auxiliary members in cooperation with local medical societies work with high school guidance counselors in providing career counseling, scholarships, loans, program material and speakers to help step up interest in medical and allied health careers.

Q. *What is the Auxiliary's work in the TB Speaking project?*

A. The Auxiliary in conjunction with the Michigan Tuberculosis and Respiratory Disease Association sponsors a contest for high school students to enter scripts for a radio talk. Some 80 schools participated in the project and 23 radio stations agreed to arrange broadcasts. Six scripts are selected for state awards.

Q. *What is the newest undertaking of the Auxiliary?*

A. The collection of sample drugs from the doctors' offices, old medical equipment, instruments, office furniture and such. These are sent to World Medical Relief in Detroit or other worthy organizations. This is the work of the International Health Activities Committee.

Medical Progress

Within the next 10 years, today's physician will have to forget about half of what he knows now because it will be out of date—thanks to the rapid pace of medical research. Half of what the physician will need to know 10 years from now has not yet been discovered.—Dr. Edward R. Annis, Miami, Fla.

Recognition!

The publishers of the *Current Medical Digest* were so impressed with the message written by Orlen J. Johnson, M.D., MSMS President, on his President's Page in the November Journal, they reprinted it in their February issue. Permission was granted to use the article, "When You Tell, Be Sure to Sell," with the proper credit line.

MSMS Centennial Series

Economic Problems Command Considerable Attention In 1936

By William J. Stapleton, Jr., M.D.
Detroit, Michigan
MSMS Historian

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number and will continue through August, 1965.*

The year 1936 I remember very well. Grover Penberthy and myself were candidates in the fall of 1935 for the presidency of the Michigan State Medical Society. I lost. It is interesting as one takes up the history of MSMS from year to year to see that the Society is always looking to the future and the best interests of medicine and society.

In February, 1936, three new Postgraduate Education Extension Centers were added—in Bay City, in Cadillac, and in Traverse city.

In cooperation with the University of Michigan and the Commanding General, 6th Corps Area, U. S. Army and the Commandant, 9th Naval District, U. S. Navy, reserve officers in Michigan, Illinois, and Wisconsin could attend an inactive duty school. Courses included ward walks, observation of surgery. Conferences covered internal medicine, general surgery, oral and dental surgery.

The total MSMS membership was 3,650—a gain of 257.



The Author
WILLIAM J.
STAPLETON, JR., M.D.
MSMS Historian

PRESIDENT PENBERTHY proposed a five-year program.

The following is a digest: (1) High ethical standards of practice must be maintained with more emphasis on postgraduate education. (2) It is necessary that capable officers be elected to the county and state societies. (3) All members must support committee activities. (4) Efficient county society executive committees should be organized. (5) To aid public education, Medical Information Bureaus should be set up in each county. (6) The evils of Socialization of Medicine should be made known to the public. (7) Certain legislation must be furthered: a professional qualifications act, a change in the medical practice act, laws regarding care of afflicted children, and a law to combat corporate practice of medicine.



Grover C. Penberthy, M.D.
President 1935-36

During 1935-36, physicians operated on thousands of people under the Afflicted and Crippled Children's program without receiving any fees (despite laws which call for reasonable compensation) except during the period May 28-June 30, 1935 when they were paid ¼ the normal fee. During the entire period the physicians of Michigan saved the state of Michigan 3.3 million dollars.

* * *

MSMS PRESENTED a filter system accepted by the Michigan Probate Judges Association and the Michigan Hospital Association, to care for these children.

The plan consisted of two filters—an economic filter

and a medical filter. The economic filter's duty was to establish a code whereby economic self-sustaining patients could be eliminated. The medical filter determined the medical surgical urgency of the case. The medical filter was composed of members of the County Medical Societies. When these two phases were completed the Judge of Probate signed a statement, and the patient entered a hospital of his own choosing.

Twenty-one booklets issued by MSMS and relating to state medicine, sickness insurance, and socialization of medicine were mailed to high schools and to the public in general. Any doctor could request that these booklets be sent to any group or to any individual.

* * *

THE 1935 HOUSE OF DELEGATES instructed The Council to move the MSMS executive offices to Lansing and to employ a full-time Executive Secretary. Mr. William J. Burns was hired as secretary. Mr. Burns retired January 1, 1964 after a most successful career with the Michigan State Medical Society for almost 29 years.

The Emergency Relief Administration provided in 1936 only for work in a doctor's office or in the patient's home. The welfare client could call a doctor for himself or for his family. Neither the physician nor the patient needed authorization. After the service, the doctor mailed to the Welfare Office a form which includes (a) Name of patient, (b) Nature of service, (c) Diagnosis, (d) Classification of illness, (e) Charge for service, mileage and medicine. The welfare patient was to receive only necessary medical care. If unusually expensive treatment was needed, a request and an explanation was made to the relief administration. It was allowed if the treatment was deemed necessary. A committee of three doctors was appointed by the president of county medical society to act in an advisory capacity to the relief administration. It met once a month and reviewed doctors' bills.

The 20th Annual Convention of the American College of Physicians and Surgeons met in Detroit on March 2-6. The College wants to set up an examination board, the passing of whose examinations will be evidence of qualification for specialization in internal medicine.

* * *

THE NEW PROGRAM CREATED by the MSMS Executive Committee together with the Bureau of Child Hygiene and Public Health Nursing of the State Department of Health sought to reduce infant and maternal mortality through more and better pre-natal and post-natal care, the doctor to provide their treatment, the public health nurse to educate expectant mothers. Plans called for the enrollment of six physicians, six sanitary engineers, and four nurses in three to four months' courses at the University of Michigan to fit themselves for administrative duties in new or existing county or district departments of health.

Another step this year was the establishment of "The Public Information Bureau" to bring the physician into closer contact with groups of laymen. The idea was given to the Public Relations Committee to develop. Its work called for the creation in each county of a speaker's bureau.

In passing, we mention that there was in existence the Detroit Doctors Symphony Orchestra of 50 pieces and its Glee Club of 24 members under the direction of George Miquille, virtuoso cellist with the Detroit Symphony Orchestra. It is too bad that it went out of existence after a few years.

Expansion of maternal and child health services in Michigan under the Social Security Act made possible the establishment of county-wide nursing in Gratiot, Tuscola, Muskegon, Montcalm, and Clinton Counties.

The October MSMS Journal reported that at the next session of the Michigan Legislature a Basic Science Bill will be introduced. Its purpose would be to elevate the standard of training for all those who purport to practice the art of healing in Michigan—doctors, osteopaths, chiropractors, etc. It would cover the following subjects: physiology, chemistry, anatomy, pathology, and bacteriology, as well as public health and hygiene. These subjects are to be taught in regular institutions recognized by higher educational departments of the State. The bill would not affect the standards of any practicing physician.

* * *

L. FERNALD FOSTER, M.D., was chosen MSMS Secretary.

Approximately 215 doctors were licensed by examination during 1936 to practice medicine in the state of Michigan. Ninety-seven were from the University of Michigan, eighty-two were from the Medical Department of Wayne University, and thirty-nine came from medical schools outside the state.

Reading the digest of the work of the President, Officers, and Council, one sees that Doctor Penberthy's year as President was a most successful one for the advancement of medicine in our state.

Describes Placement Service

The effective work of the Michigan Health Council to place doctors, to help educate the public about good health, and to help recruit young people for health careers is described in the January-February issue of *The Michigan Nurse*. The article was written by John A. Doherty, MHC executive secretary.

Editorial Comment

Medicare Sales Pitch Splits One into Three

Detroit Free Press, January 27, 1964

ONCE, just once, before this old earth turns to ashes, we'd like to see a bureaucrat get a simple lesson through his head:

The people and the taxpayers are the same; the government and the people are the same; the government and the taxpayers are the same.

To listen to words from the Washington wind-tunnel, you'd get the idea that these are three separate and distinct sets of bodies. Bureaucrats somehow create the impression—possibly because they don't know any better—that there are poor, downtrodden Peepul, who have nothing but the vote; there are the Taxpayers, all of whom are rich as General Motors, and there is good old kindly Uncle Sam, who takes from the Taxpayer and gives to the Peepul.

Witness as an example of this Alanson Willcox, general counsel of the Department of Health, Education and Welfare, who spoke in Detroit the other day in favor of medical care for the aged under Social Security.

"Most leaders of the prepayment movement (Social Security deductions, he means) have come to the conclusion that the 18 million aged cannot be adequately protected by the voluntary system either at their own expense or at the expense of younger contributors," he said. "The question, then, is what form government aid should take."

There you have the classic trio. The poor people, aged and younger, who can't afford medical payments; the benevolent Government, which is going to help, and the taxpayer, who will pick up the tab.

The catch, as we said earlier, is that they're all the same. There aren't any other people in this country except old people and younger people. If they can't pay medical costs between them, nobody can.

The key word of course, is not "cannot" but "voluntary." What Willcox really said was that some people don't want compulsory medical care for the aged, but the bureaucrats think they ought to have it. Therefore, the kindly Government intends to force everybody to join against his will.

In short, the Government (us) intends to make the Taxpayers (us) kick in to provide medical care for the Peepul (also us).

If he'd just said, "We bureaucrats are going to make you healthy even if we kill you in the process," it wouldn't have taken all this explanation.

Family Doctor

Lansing State Journal, February 1, 1964

For those who have feared the family doctor is a vanishing American in an age of specialization, there is heartening news from the annual meeting of the New Jersey Academy of General Practice in Atlantic City.

The convention reported a resurgence of the general practitioner, reflecting an intensification of efforts to increase his prestige in the profession, and to interest medical students in general practice. There is a public demand, too, for the services of family doctors.

As a means of reversing the specialization trend, the New Jersey Academy, in a resolution adopted at its meeting, urged that a department of family medicine be incorporated in a proposed medical school of Rutgers University.

Specialization and research are indispensable to the advance of medical science. But there will always be a need, too, for the family physician whose relationship with his patients has a potential for healing beyond the reach of medicine. He may be considered old-fashioned, but he will never be out of date.



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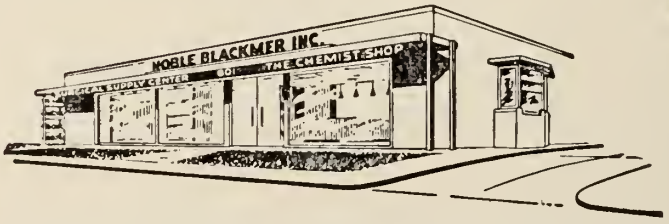
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Explains Implications Of Delegated Work

Dear Doctor:

I have your recent letter enclosing an inquiry from one of the members of your Society prompted by an article appearing in Medical Economics (issue of October 7, 1963) regarding the legal implications arising from the delegation of work by a doctor to his employees. More specifically the inquiry pertains to the use of licensed practical nurses and the practice of delegating to them the giving of injections, doing of venipunctures and other procedures "usually done by RNs in the hospital."

The statute regulating and licensing nursing in the State of Michigan is not too specific as to what a nurse licensed in any of the categories may or may not lawfully do. In general terms a registered nurse is defined as one "who has been authorized by the State to perform any professional service requiring the application of principles of nursing based on biological, physical and social sciences, such as responsible supervision of the patient requiring skill in observation of symptoms and reactions and the accurate recording of same, and execution of treatments and medications as prescribed by a licensed physician, and the application of such nursing procedures as involve understanding of causes and effect in order to safeguard life and health."

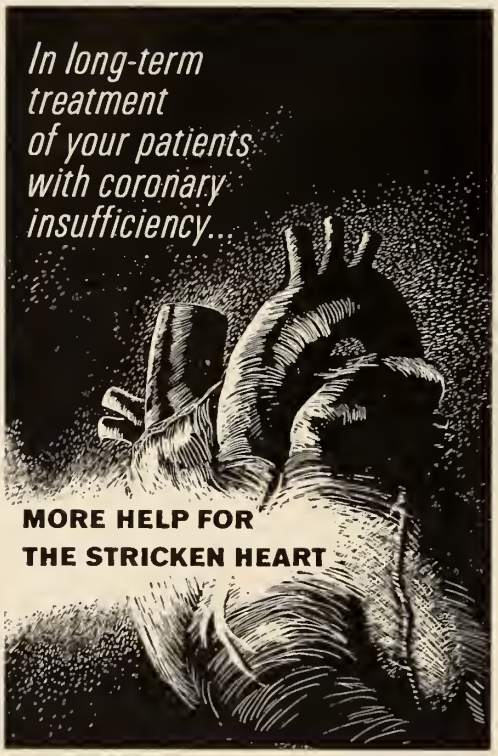
A licensed practical nurse is defined as "one who has been authorized by the State to perform such duties as are required in the physical care of the patient and in carrying out the medical orders as prescribed by a licensed physician, requiring an understanding of nursing but not requiring the professional service as defined above."

Under an opinion of the Attorney General of Michigan some years ago, it has been held that the giving of skin tests, x-ray treatments or hypodermic injections in the diagnosis or treatments of ailments or diseases by a person who is not a registered nurse or licensed medical practitioner is unlawful (O.A.G. 1937-38, p. 357).

While, admittedly, the foregoing definitions and opinion leaves much to be desired by way of clarifying the distinctions between the functions of the two classes of nurses, it must be considered unlawful for the practical nurse to do such specific acts as administering anesthetics, hypodermic injections, skin tests, x-ray treatments or other procedures which are regarded as solely within the province of the registered nurse or licensed physician.

The possible consequences to the doctor of delegating to an unlicensed person the performance of functions or procedures which





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only a licensed person can lawfully perform, might arise in any one of three ways.

1. Jeopardizing professional liability insurance coverage. This result could obtain if the doctor's professional liability insurance policy contains provisions relieving the carrier from liability for injuries arising from unlawful acts of the doctor.

2. Increased exposure to liability to the patient for injuries resulting from the acts or omissions of the unlicensed personnel.

3. Possible exposure to a charge of "unprofessional and dishonest conduct" as defined in and made a ground for suspension or revocation of license under the Michigan Medical Practice Act.

You will have noted that the Medical Economics article above referred to was prompted by a fairly recent decision of the California Supreme Court in a case involving a doctor who was charged with aiding and abetting an unlicensed person to practice medicine. In that case, the accused doctor had employed three M.D.s to assist him in giving anesthetics. All three doctors so employed were trained and experienced in anesthesia. None, however, was licensed to practice in California. Apparently the California Medical Practice Act prohibits a doctor "employing or aiding and abetting an unlicensed person to practice medicine." Although, because of extenuating circumstances, the California Court set aside revocation of the doctor's license as being too severe a penalty, it did establish the illegality of what he did.

Whether a similar result would obtain in Michigan is not at all certain due to a difference in wording of the Medical Practice Act of this State. In Michigan it is declared to be unprofessional and dishonest conduct and therefore ground for suspension or revocation of a doctor's license to "have professional connection with, or lend one's name to an illegal practitioner of medicine." This not nearly as specific language as "employing or aiding and abetting" and I am extremely doubtful that as severe a penalty as supension or revocation of a doctor's license would result in Michigan.

Regardless, however, of whether or not a doctor's license to practice might be put in jeopardy through improper delegation of duties to unlicensed persons in his office, it is certain that the other possible consequences of his so doing are sufficiently dangerous that he should exercise extreme caution in this area.

LESTER P. DODD,
Legal Counsel

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Michigan Medical Writers To Confer May 13

W. D. Snively, Jr., M.D., president of the American Medical Writers Association, will be a featured speaker at the Michigan chapter meeting in Ann Arbor, May 13. Doctor Snively will speak at the luncheon at the Michigan Union Club.

An excellent program has been arranged. The opening session at 9:30 a.m. will set the pattern. The session will offer Harlan H. Hatcher, Ph.D., U-M President; Clarence Hilberry, Ph.D., Wayne State President; Dean Ernest Gardner, M.D., Wayne State University, College of Medicine, and Dean Wm. Hubbard, M.D., U-M School of Medicine.

A copy of the program may be obtained from C. Howard Ross, M.D., 180 Underdown Road, Ann Arbor.

Blue Cross Offers Scholarships

Michigan Blue Cross will sponsor 10 nursing scholarships of $300 each in a competition open to all Michigan high school seniors and graduates. It marks the 14th year for the program which has helped train 130 nurses to reduce the Michigan nurse shortage. Application blanks are available through high school principals, Future Nurses Clubs, Michigan schools of nursing, all Blue Cross-Blue Shield offices or by writing the Michigan League for Nursing, 1000 North Washington, Lansing 6.

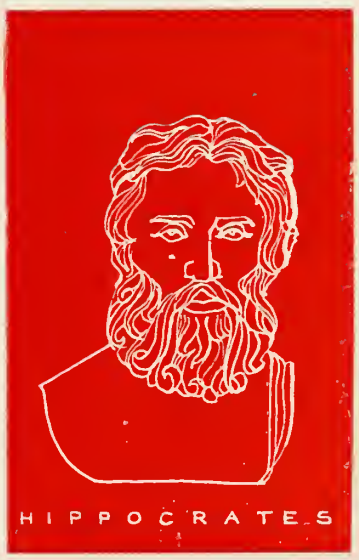
WSU Plans New Surgical Lab

The trustees of the Robert S. Marx Trust have given the first installment of the $40,000 gift to the College of Medicine at Wayne State University to help finance a new surgical laboratory. The lab will occupy the entire fourth floor of the Laboratories of the Clinical Investigation Building at 645 Mullett, Detroit.

Mott to Expand Children's Health Center

The Mott Foundation, through the Flint Board of Education, will provide $2 million to build and equip an addition to the Mott Childrens' Health Center at Flint.

The addition will permit a significant expansion in the neuropsychiatry work, which is designed to supplement services of public and voluntary agencies in allied fields. The health center also will



increase its paramedical services, such as speech, hearing and special education.

Arthur L. Tuuri, M.D., is director of the center, which was established in 1939 and moved from Hurley Hospital to its present building in 1962.

Stanford Man to Direct MSU Human Medicine Program

Andrew D. Hunt, M.D., of Stanford University, has been named dean of the program in human medicine at Michigan State University, President John A. Hannah announced Jan. 24. Dr. Hunt is an associate professor of pediatrics and director of the ambulatory service at Stanford.

At MSU, he will work with Dr. William H. Knisely, director of the Institute of Biology and Medicine. MSU established the Institute to further strengthen the biological sciences and establish a two-year program in human medicine.

Dr. Hunt received his M.D. at Cornell University in 1941, interned at the University of Pennsylvania Hospital and was a resident in pediatrics there before entering the Army in 1943. Before joining Stanford in 1959, Dr. Hunt taught at New York University.

New U-M Publication

The first issue of the new *University of Michigan Medical Center Journal* appears this month, replacing the former *Medical Bulletin*. The new editor for the new *The University of Michigan Medical Center Journal* is Harry A. Towsley, M.D., professor of pediatrics and associate director of the department of Postgraduate Medicine.

The editorial content will emphasize scientific presentations of practical value to the physician, review articles, postgraduate medicine material, news of the Medical Center and of its alumni.

The first issue will appear this month. There will be six issues a year. Subscriptions will be $5.00.

Midwest Allergy Forum Set for Detroit, November

The Michigan Allergy Society will sponsor the Midwest Forum on Allergy, Saturday and Sunday, November 14-15, in Detroit. The society will be host to members from the 10 participating allergy societies of the Midwest.

The meetings will be held at the Ford Hospital Auditorium; the Harlan House will be the convention

Recent reports suggest...insulin and sulfonylureas may accelerate lipogenesis,[1-5]...serum "insulin" levels are often elevated in obese diabetics[2,3,6]...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

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In the obese diabetic (ketoacidosis-resistant), DBI (phenformin HCl) with a proper diet: **A.** acts to reduce high blood sugar without increasing fat synthesis or weight gain. **B.** does not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal levels. **C.** favors reduction of weight.

In the ketoacidosis-resistant obese diabetic not amenable to diet alone, hypoglycemic DBI (phenformin HCl) appears to help avoid weight gain or reduce adiposity, factors which otherwise tend to make blood sugar control more difficult and to increase the likelihood of complications. However, in the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic agent.

Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

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hotel. Isreal Wiener, M.D. and James A. McLean, M.D. have been designated as co-chairmen of the Forum.

Boosts Ophthalmological Research

A new fund to support research in ophthalmology has been established at the University of Michigan Medical School thanks to the gift of $200,961 to the Department of Ophthalmology from the Snyder Ophthalmic Foundation. The man for whom the fund is named, Walter H. Snyder, M.D., was an ophthalmologist and an 1891 graduate of the U-M Medical School.

Offer "Nuclear Medicine" Course

A two-day course in "Nuclear Medicine" will be given at the University Hospital, Ann Arbor, April 20 and 21, by Wm. H. Beierwaltes, M.D., Coordinator, Nuclear Medicine Unit, and staff. Physicians in hospital radioisotope units and members of the radioisotope committees of hospitals are encouraged to attend this course. Inquiries should be addressed to John M. Sheldon, M.D., Director, Department of Postgraduate Medicine, University Hospital, Ann Arbor.

U-M Medical Alumni Elect

E. Thurston Thieme, M.D., Ann Arbor, has been elected president of The University of Michigan Medical Center Alumni Society for his third one-year term. Elected vice-president was Harry A. Towsley, M.D., Ann Arbor.

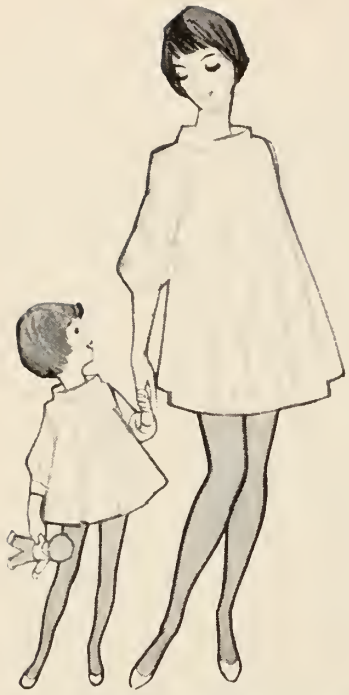
The Alumni Society will hold its next conference October 15, 16 and 17 in Ann Arbor.

Symposium on "School Health" Offered at Flint, May 13

The C. S. Mott Foundation Children's Health Center will sponsor the first Mott Pediatric Symposium on May 13 about "School Health." Distinguished guests will include Harry Bakwin, M.D., New York; John L. Reichert, M.D., Chicago, and Frank Falkner, M.D., Louisville. The program will be held at the Mott Foundation Children's Health Center, 806 West Sixth Avenue, Flint.

Advance registration is requested by the Center.





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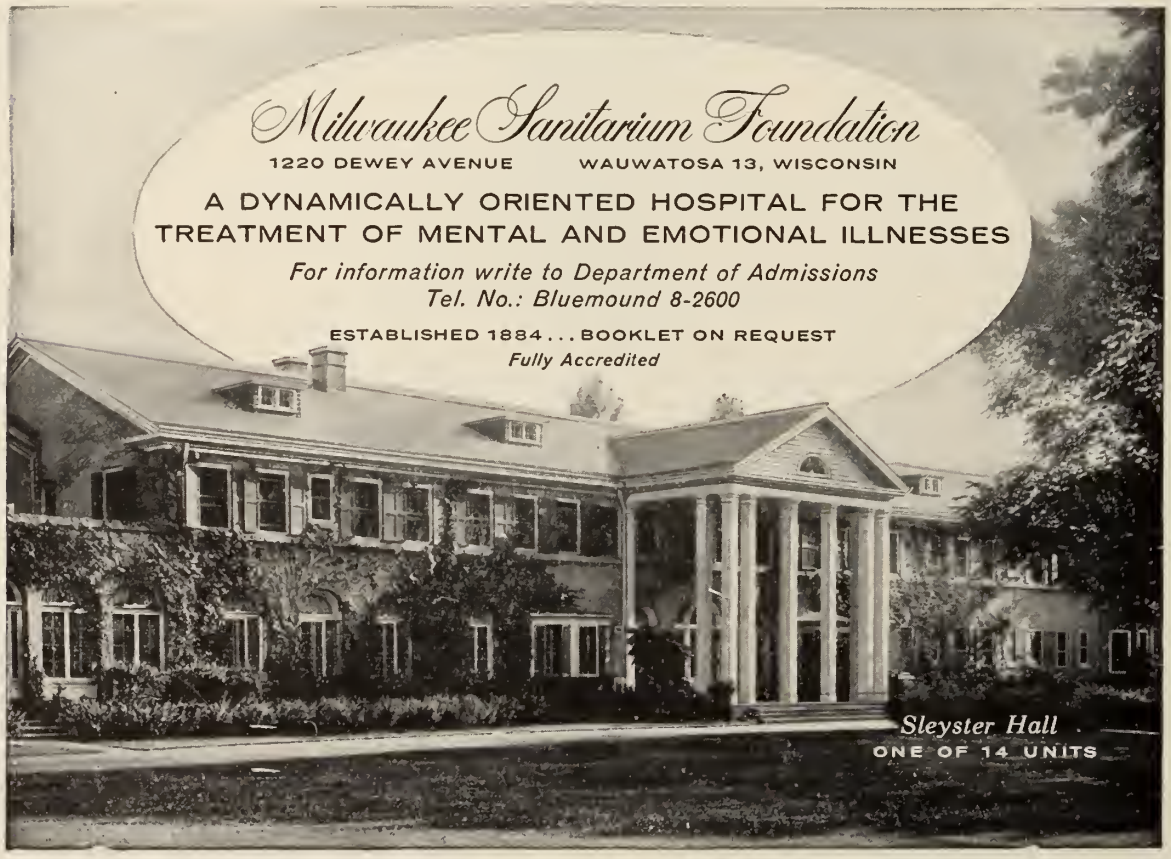
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MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Cigarettes and Health

On January 11, the advisory committee to the Surgeon General released its long-awaited report on cigarette smoking and health. Their conclusion, after careful and painstaking evaluation of numerous research studies, was that cigarette smoking is a cause of lung cancer and chronic bronchitis and is related to emphysema, heart disease, and other serious conditions.

Their judgment: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action."

To help determine how it could best take such remedial action, the Michigan Department of Health asked Governor Romney to call a conference on the cigarette hazard. Such a conference was held on January 22, with representatives of state agencies, legislative committees, professional, hospital, and voluntary health agencies, and the communications media in attendance. At the outset, all members of the conference agreed that attempts at compulsion or prohibition would be neither proper nor effective. On this assumption, the conference directed its efforts at determining what practical steps could be taken in education and in legislation most effectively to protect the health of the people.

1. *Legislation.*—The conference recommended legislative action which would make existing laws with regard to the smoking of young persons more realistic and more readily enforceable, which would curb the ready availability of cigarettes to young people, and which would provide funds for health department programs against cigarette smoking and its effects.

2. *Education.*—The conference recommended strengthening school health programs, coordinating programs of public and voluntary groups which might be carried out in the schools, supporting a program for national labeling of cigarette packages as dangerous to health, and encouraging the healing professions to discourage cigarette smoking both by precept and example.

Action to implement these recommendations was begun immediately and a continuing and relentless program against cigarette smoking will be waged by state and local health departments in Michigan. As a part of this effort, it is our earnest hope that every physician will endeavor to do whatever is possible to ultimately establish a climate of opinion in which cigarette smoking is no longer a socially acceptable habit. It is our hope that within another generation, cigarettes will have gone the way of the wad of chewing tobacco and that the ash tray will join the spittoon in a well-deserved limbo.

Polio Immunization Policy

The Michigan Department of Health recommends the use of either Salk or oral polio vaccine in routine immunizations for protection against poliomyelitis, and will continue to provide Salk vaccine in combination with diphtheria, tetanus and pertussis for infants and preschool children.

Inasmuch as both the killed and oral types of poliomyelitis vaccines are now licensed and available to physicians, the decision as to which type of vaccine an individual physician will use in his office rests with that physician.

Mass Immunization Programs in the Presence of an Outbreak of Polio

An outbreak of paralytic poliomyelitis is defined as three cases occurring within a period of one month, at least two of which are confirmed by the laboratory as being caused by the same type of poliomyelitis virus.

In the presence of an outbreak, oral poliomyelitis vaccine should be used on a type specific basis with the aim of protecting everyone in the community (for the epidemic type involved) in as short a time as possible, and with special emphasis upon preschool and school age children without regard to prior immunization histories.

Any such program should include:

(A) The subsequent administration of the other two types of oral poliomyelitis vaccine in accordance with approved schedules.

(B) The maintenance of an individual record for each person who receives vaccine.

Mass Immunization Programs in the Absence of an Epidemic

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in the absence of an epidemic, as well as the responsibility for the organization and the conduct of same, is that of the director of the local full-time health department, in conjunction with the local medical societies. Upon request, the Michigan Department of Health will assist the local health officer or the medical societies in areas without full-time local health officers in evaluating the need for such mass immunization programs.

When any such program is instituted, the following shall be the obligation of the local health department in conjunction with the local medical societies:

(A) To maintain the level of community protection thus achieved by specific plans for a continuing immunization program with special emphasis upon the immunization of all infants and other new entrants into the community.

(B) To secure adequate levels of community-wide protection against smallpox, diphtheria, tetanus, and whooping cough as well as polio.

(C) To provide an individual record for each person who receives vaccine.

(D) To carry out such a program when enteroviruses are less likely to be prevalent. Late fall, winter, and early spring are generally considered to be the optimum time to avoid failure of immunization in persons who may have interfering virus infections.

Attention is also called to the following statement which appeared among the recommendations of the advisory committee on oral poliomyelitis vaccine which the Surgeon General offered in a release on December 19, 1962:

"Because the need for immunization diminishes with advancing age and because the potential risks of (oral poliomyelitis) vaccine are believed by some to exist in adults, especially above the age of 30 (oral poliomyelitis) vaccination should be used for adults only with the full recognition of its very small risk."

From Our Public Relations Library

The following books are recommended to interested physicians as stimulating and informative. Send a note to MSMS Public Relations Department and we will send them for your perusal by return mail:

"Henry E. Sigerist on the Sociology of Medicine," edited by Milton I. Roemer, M.D.

"The Art of Problem Solving" by Edward Hodnett.

Brief and to the Point

WILLIAM L. HARRIGAN, M.D., received an honorary doctor of law degree from Central Michigan University at the midyear commencement. Doctor Harrigan is medical superintendent of the Mount Pleasant Home and Training School. **CHARLES E. SNYDER, M.D.**, Swartz Creek, is serving as lieutenant governor of Kiwanis for District 12. A memorial fund honoring the late **MAURICE HOGAN, M.D.**, Bad Axe, has reached $468, according to the Huron County Unit of the American Cancer Society. These funds have been received from relatives, friends, neighbors and former patients of Doctor Hogan. **ARTHUR J. VORWALD, M.D.**, Detroit, was one of the speakers February 15 at the "High School Press Conference on Cigarette Smoking and Health" at the University of Detroit.

* * *

The new president of the Kalamazoo County Red Cross Chapter is **LAWRENCE R. BANNER, M.D.**, who at the recent annual chapter meeting received a plaque for his contributions to the Kalamazoo County Blood Program during its 10-year existence. The first speaker at the Public Health Pathology Lecture Series at Meharry Medical College was **JOHN F. BURTON, M.D.**, Detroit. Chosen as the Flint Jaycees "Young Man of the Year" was **ROBERT E. ANDERSON, M.D.**, long active in youth and athletic programs at Flint. His many contributions include the five-year study of school injuries and general health. **MARION SPENCER DEWEESE, M.D.**, Ann Arbor, will begin duties June 1 as professor of surgery and chairman of the Department of Surgery at the University of Missouri School of Medicine. Dr. Deweese has been with the University of Michigan continuously since 1948.

* * *

The Grosse Pointe *News* recently wrote an interesting feature about **CLARENCE L. CANDLER, M.D.**, a past president of the Wayne County Medical Society. The *News* cited him for more than 50 years of practice and also as "a crusading politician and dedicated fund raiser." Cited recently for 20 years of "loyal and faithful service" for the Selective Service System was **CHARLES A. COOPER, M.D.**, Stambaugh. **CHARLES E. DARLING, M.D.**, Detroit, will speak at a "Symposium on Episiotomy" at the Scientific Assembly of The American Academy





of General Practice in Atlantic City, New Jersey, in April. The Pfizer Paul-Lewis Award recently went to **DR. MARSHALL NIRENBERG**, biochemist of the National Institutes of Health. Doctor Nirenberg holds a Ph.D. from the University of Michigan.

* * *

A talk about "Carcinoma of the Lung and the Effect of Smoking" was given recently by **RICHARD A. RASMUSSEN, M.D.**, Grand Rapids, to the Chippewa-Mackinac County Medical Society. The talk was sponsored by the Michigan Cancer Coordinating Committee. **RALPH S. GREEN, M.D.**, Rochester, spoke at the National Association of Private Psychiatric Hospitals at Fort Lauderdale about "The Private Psychiatric Hospital and the Local Community." **BRUCE PROCTOR, M.D.**, Detroit, gave a lecture to the Royal Society of Medicine in London recently on the subject of "The Surgical Anatomy and Embryology of the Middle Ear." He also received an award of the American Academy of Ophthalmology and Otolaryngology in the 1963 New York meeting for services rendered in scientific exhibits, home study courses, and scientific papers.

* * *

DONALD A. KOCH, M.D., Port Huron, and **EUGENE L. FREITAS, M.D.**, Grosse Pointe Woods, were made fellows of the American College of Radiology at the annual meeting recently at Tucson. **RUSSELL L. FINCH, M.D.**, is the new physician and surgeon serving the Michigan Reformatory and Michigan Training Unit at Ionia. Doctor Finch has served the penal institutions at Jackson, Marquette and Ionia since 1922. He succeeds **HAROLD MITCHELL, M.D.**, who retired in December.

THORACIC SOCIETY PLANS N. Y. SESSION

The 59th Annual Meeting of the American Thoracic Society will present a variety of medical sessions at the Statler Hilton Hotel, New York City, May 24-27. For further information, write James F. Hammarsten, M.D., American Thoracic Society, 1790 Broadway, New York, N. Y.

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IN MEMORIAM

CLARENCE E. BURT, M.D., 92, Ithaca physician since 1914, died January 16, 1964.

A graduate of the University of Illinois Medical School, Doctor Burt served his internship at Cook County Hospital, Chicago. Doctor Burt was an eye, ear, nose and throat specialist.

GLENN L. COAN, M.D., 72, Wyandotte surgeon for 45 years, died December 24, 1963.

A 1915 graduate of the old Detroit Medical College, Doctor Coan served his internship at Providence Hospital, Detroit, before entering service in World War I.

Doctor Coan served on the Ethics Committee of the Wayne County Medical Society for more than 20 years. He was on the staff of Wyandotte General Hospital and a member of the American College of Surgeons. He was a Life Member of the Michigan State Medical Society.

LELAND G. HILLIER, M.D., 69, Detroit physician for 43 years, died January 11, 1964.

A graduate of McGill University school of medicine at Montreal, Doctor Hillier interned at Harper Hospital, Detroit, from 1920 to 1922 and served his residency at Woman's Hospital, Detroit, from 1922 to 1926. Doctor Hillier was a member of the Graduate Society of McGill University and the College of Physicians and Surgeons of Ontario.

GEORGE B. HOOPS, M.D., 86, Detroit physician, died December 29, 1963.

Doctor Hoops served for over 20 years as chief of the medical staff at Grace Hospital; he was also chairman of the Wayne County Medical Society Ethics Committee during the same period. He was a member of the American College of Physicians, American College of Internal Medicine and a Life Member of the Michigan State Medical Society.

CLEMENT E. LOCKWOOD, M.D., 80, Holly physician, died January 19, 1964.

Doctor Lockwood was graduated in 1923 from the University of Michigan Medical School. He was on the staff of McLaren General Hospital, Flint. He was a member of Phi Alpha Kappa medical fraternity, a Past President of the Michigan Homeopathic Medical Society and a Life Member of the Michigan State Medical Society.

THOMAS C. STARRS, M.D., 82, Detroit psychiatrist, died January 25, 1964.

Doctor Starrs was graduated from Detroit College of Medicine and Surgery in 1906. He began his psychiatric practice after World War I and served for many years as psychiatrist to the Friend of the Court.

He was a Life Member of the Michigan State Medical Society.

CLAUDE W. TURBETT, M.D., 83, Detroit physician for 53 years, died January 4, 1964.

A graduate of the Detroit College of Medicine, Doctor Turbett was a Life Member of the Michigan State Medical Society.

March, 1964





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Michigan Authors

C. R. Lam, M.D., Henry Gale, M.D., and Ellet Drake, M.D., Detroit, "Surgical Treatment of Left Ventricular Aneurysms," *Journal of the American Medical Association*, January 4, 1964.

R. E. Dean, M.D., J. H. Andrew, M.D., and R. C. Read, M.D., FACS, Detroit, "The Red Cell Factor in Renal Damage from Angiographic Media," *Journal of the American Medical Association*, January 4, 1964.

R. H. Bartlett, M.D., W. H. Falor, M.D., and C. J. D. Zarafonetis, M.D., Ann Arbor, "Lipid Studies on Human Lymph and Chyle," *Journal of the American Medical Association*, January 11, 1964.

R. M. O'Bryan, M.D., R. W. Smith, Jr., M.D., Gerald Fine, M.D., and R. C. Mellinger, M.D., Detroit, "Congenital Adrenocortical Hyperplasia," *Journal of the American Medical Association*, January 25, 1964.

Guenter Corssen, M.D., and I. A. Skora, M.D., Ann Arbor, "Addiction Reactions in Cultured Human Cells," *Journal of the American Medical Association*, February 1, 1964.

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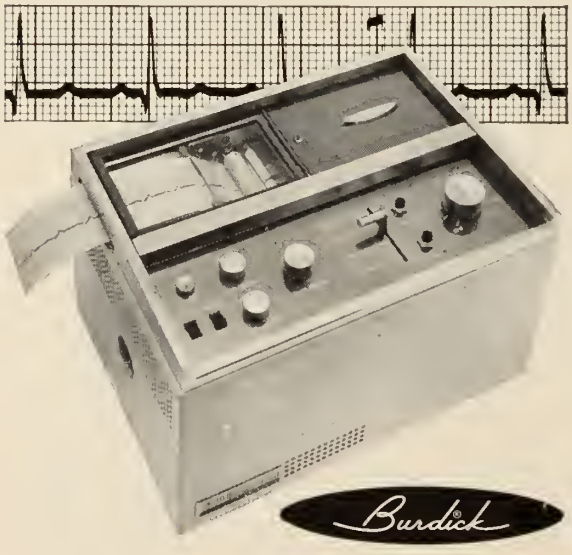
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April, 1964

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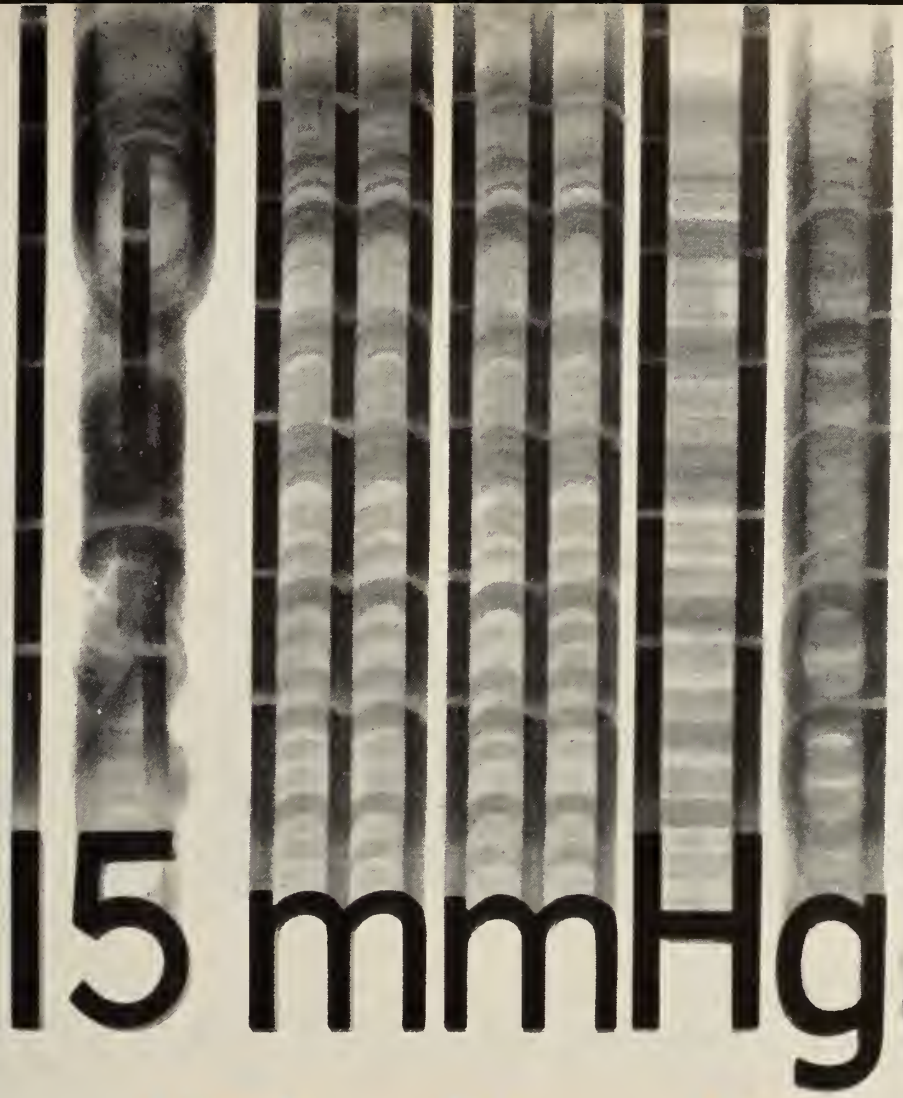
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1. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, Calif., Nov. 25-28, 1962.
2. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc:* 11:945 (Oct.) 1963.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

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Usual adult dosage: 1 or 2 400 mg. tablets t.i.d.

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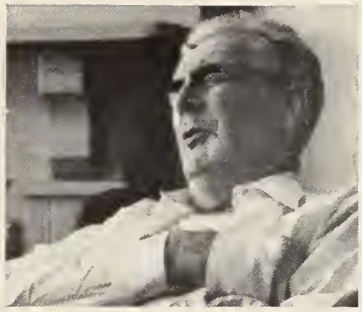
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The insomniac



The tense, nervous patient



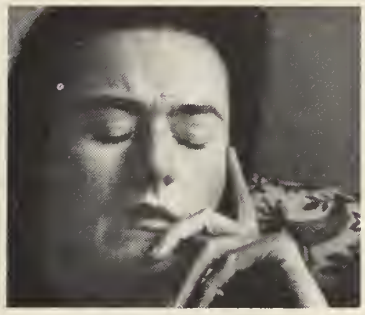
The heart-disease patient



The surgical patient



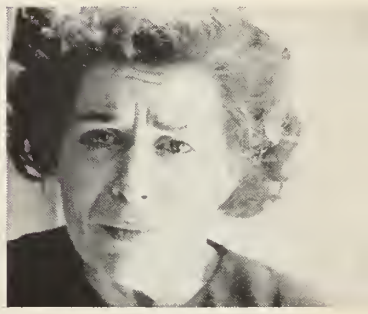
The girl with dermatosis



Tension headache



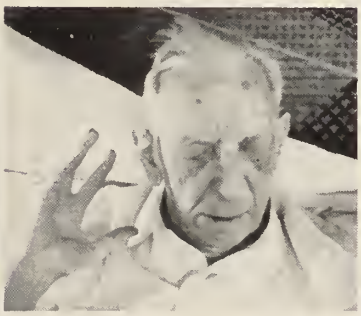
The woman in menopause



Anxious depression



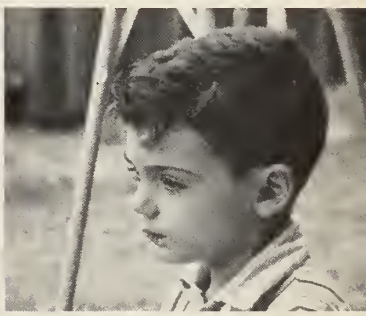
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President's Page

MSMS IS ORGANIZATION FOR EVERY DOCTOR



Arlen J. Johnson M.D.

President
Michigan State Medical Society

The Council of the Michigan State Medical Society has taken action, after due deliberation, on the report of a study of MSMS organization. It was an intelligent and practical report prepared by our administrative officers and economic consultant. It evaluated the organization's activities and outlined its purposes. Where feasible it was implemented, otherwise studies were directed to the appropriate committee.

Development of programs and activities in an organization such as ours takes time with interest, industry and energy by the members. However, a program to get all eligible ethical doctors of medicine to become members of the Michigan State Medical Society should have the active support of all present members.

The Constitution of MSMS states it is organized "to bring into one organization the doctors of medicine of the State of Michigan and, in cooperation with other states, to form the AMA." It does not say some of certain doctors of medicine, it does mean that it is an organization for all ethical doctors.

Presently only 77 per cent of those registered to practice medicine in Michigan are members. This is the only factual measurement available. It is evident however, that many unlicensed physicians, now eligible by action of the AMA and MSMS House of Delegates, in research, teaching and administrative positions are not active members of these organizations. They should be invited and urged to join. Both the individual and the organization would benefit.

Regardless of the individual's field of medical activity there is an underlying relationship with the medical profession as a whole which, if utilized, will enhance their actions in even a restricted area of endeavor.

It is the objective and intent of the MSMS to develop programs to serve all M.D.'s, regardless of professional endeavors. If this end is to be attained, the activity and advice of all physicians is essential. To not belong is a weak protest against organizational activity and strong rejection of professional obligation.

Attendance at MCI Surpasses Recent Years

(Photos will appear in May Issue)



Speakers were pleased and exhibitors were elated with the excellent attendance at the 1964 Michigan Clinical Institute.

The registration of doctors of medicine totaled 1,138, which is more than the 1963 attendance—and more also than the 1962 attendance.

Registration of doctors, interns, residents, students, nurses, medical assistants, and others totaled 2,285.

The total figure of persons who attended MCI activities zoomed beyond the 3000-mark by adding the more than 800 who attended the evening seminars in Detroit.

General chairman for MCI, Kenneth H. Johnson, M.D., Lansing, reports that a total of 116 M.D.'s and Ph.D.'s spoke during the three-day program, March 11-12-13 at the Sheraton-Cadillac Hotel. The speakers came from Michigan, Virginia, Minnesota, Florida, Pennsylvania, New York, and Ontario.

Responsible for the entire MCI program was a committee with J. L. Posch, M.D., chairman.

There were two programs each morning over closed circuit television from Detroit Receiving Hospital, the programs produced by Smith, Kline & French medical color television unit. D. H. Kaump, M.D., Ann Arbor, served as chairman of the MCI Committee on Television.

Special lecturers were offered by the Michigan Foundation for Medical and Health Education, the Michigan Cancer Coordinating Committee and the Michigan Heart Association.

Among the ancillary groups which met in conjunction with MCI were the Woman's Auxiliary to MSMS; Michigan State Medical Assistants Society, Michigan Branch, American Academy of Pediatrics; Michigan State Neurosurgical Society; Michigan Academy of Plastic Surgery; Michigan Chapter, American College of Chest Physicians; Michigan Diabetes Association Clinical Society; Michigan Regional Committee on Trauma, American College of Surgeons; Wayne State University College of Medicine Alumni Association, and the University of Michigan Medical Center Alumni Society.

Ten organizations cooperated in sponsoring the 1964 Michigan Clinical Institute.



PHOTOS FROM 1964 MSMS COUNTY SECRETARIES PUBLIC RELATIONS SEMINAR

Above—Experiences with health projects are discussed by MSMS President Johnson *(far left)*, with presidents of three of the foundations which were cited. Visiting together are *(left to right)*, Doctor Johnson, William J. Norton, president of the MacGregor Foundation, Detroit; Charles S. Mott, president of the Mott Foundation, Flint, and Stanley S. Kresge, president of the Kresge Foundation, Detroit.

At Right—Among the Detroit award winners were William J. Stapleton, Jr., M.D. *(left)*, MSMS Historian, and Mrs. Irene M. Auberlin, president of World Medical Relief.

Below—Four Ann Arbor doctors were honored as presidents of national organizations and A. C. Furstenberg, M.D. *(third from left)*, received a "Distinguished Health Service Award." Left to right are Kenneth P. Mathews, M.D.; James LeRoy Wilson, M.D.; Doctor Furstenberg, MSMS President Johnson; Myron E. Wegman, M.D.; and Reed O. Dingman, M.D.





1964 MSMS Awardees

DISTINGUISHED HEALTH SERVICE AWARD

Frederick A. Coller, M.D., Ann Arbor
Dean Emeritus A. C. Furstenberg, M.D., Ann Arbor
William J. Stapleton, Jr., M.D., Detroit

PRESIDENT'S AWARD (Presidents of National Organizations)

Reed O. Dingman, M.D., Ann Arbor
American Society of Plastic and Reconstructive Surgery
A. E. Heustis, M.D., Lansing
Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities
R. L. Mainwaring, M.D., Detroit
American Association of Blood Banks
Kenneth P. Mathews, M.D., Ann Arbor
American Academy of Allergists
E. C. Swanson, M.D., Vassar
Federation of State Medical Boards of the United States
Myron E. Wegman, M.D., Ann Arbor
Association of Schools of Public Health
James Leroy Wilson, M.D., Ann Arbor
American Pediatric Society

OUTSTANDING HEALTH SERVICE AWARD (Organization)

Dow Foundation, Midland
Kalamazoo Foundation, Kalamazoo
Kellogg Foundation, Battle Creek
Kresge Foundation, Detroit
MacGregor Foundation, Detroit
Mott Foundation, Flint

OUTSTANDING HEALTH SERVICE AWARD (Individual)

Mrs. Irene M. Auberlin, Detroit
President, World Medical Relief
Gordon H. Scott, Ph.D.
Wayne State University College of Medicine
Robert Gillespie, St. Joseph
President, American Pharmaceutical Association
Alvin M. Bentley, Owosso
Michigan Chairman, Project HOPE
Harry J. Loynd, Detroit
President, Parke-Davis Company
Sen. Frank Beadle, St. Clair
Rep. Edson V. Root, Jr., Bangor

OUTSTANDING HEALTH SERVICE AWARD (Communications)

Newspapers:

Benton Harbor News-Palladium
Flint Journal
Bay City Times
St. Joseph Herald Press

Newspapermen:

Jean Worth, Escanaba
Frank Angelo, *Detroit Free Press*
Martin Hayden, *Detroit News*

Radio Stations:

WILS, Lansing
WDET, Detroit
WJR, Detroit

TV Stations:

WOOD-TV, Grand Rapids
WJIM-TV, Lansing



"Outstanding Health Service Awards" were presented to two Michigan legislators—Senator Frank Beadle, seated, of St. Clair, and Representative Edson V. Root, Jr., of Bangor.

Comments from AMA re Medical Aspects of Driver Limitation

The MSMS Council and MSMS Committee on Study of Prevention of Highway Accidents believes that many Michigan physicians will be interested in an AMA statement on "Medical Aspects of Driver Limitation." Interested MSMS members may obtain a copy by writing to MSMS, Box 152, East Lansing; or the AMA, 535 N. Dearborn, Chicago.

Following are several excerpts from the position paper:

The following nine general areas are the most significant of the medical problems which must be evaluated to determine if driver limitation exists:

1. Mental retardation below the ability to read.
2. Uncompensated arthritic, skeletal, and amputation deformities likely to interfere with safe driving.
3. Neurological defects, e.g., spastic defects; ataxia; paralysis agitans; intractable seizure states or blackouts; intractable narcolepsy.
4. Cardiovascular defects, e.g., intractable Stokes-Adams Syndrome; intractable angina pectoris; uncontrollable malignant hypertension; severe or intractable cardiac decompensation with dyspnea at rest; generalized and severe arteriosclerotic disease of incapacitating degree.
5. Psychiatric problems, e.g., intractable psychoneurotic disorders, especially sustained hostile, aggressive, and paranoid states; agitated depression.
6. Obesity (gross and severe).
7. Gross sensory deficits, e.g., severe impairments of corrected central visual acuity; severe reductions in visual fields; severe impairment of hearing.
8. Chronic alcoholism and drug addiction.
9. Other medical conditions demanding individual analysis.

RECOMMENDATIONS

It is recommended that a medical examination for driver limitation be conducted at least under the following conditions:

1. When a license applicant displays an obviously impaired physical function.
2. When a driver has been involved in multiple accidents within a short calendar period.
3. When a driver must be placed in the "assigned risk" pool for insurance underwriting because of refusal by various commercial insurance carriers to assume the risk.
4. When a driver voluntarily suggests that he "blacked out" or that medical problems contributed to an accident.

Seek Equipment for Medical Dispensary at Fort Wilkins

MSMS members have been invited to contribute medical equipment or photographs of medical equipment of the 1840-1870 period to help furnish the medical dispensary at old Fort Wilkins at Copper Harbor.

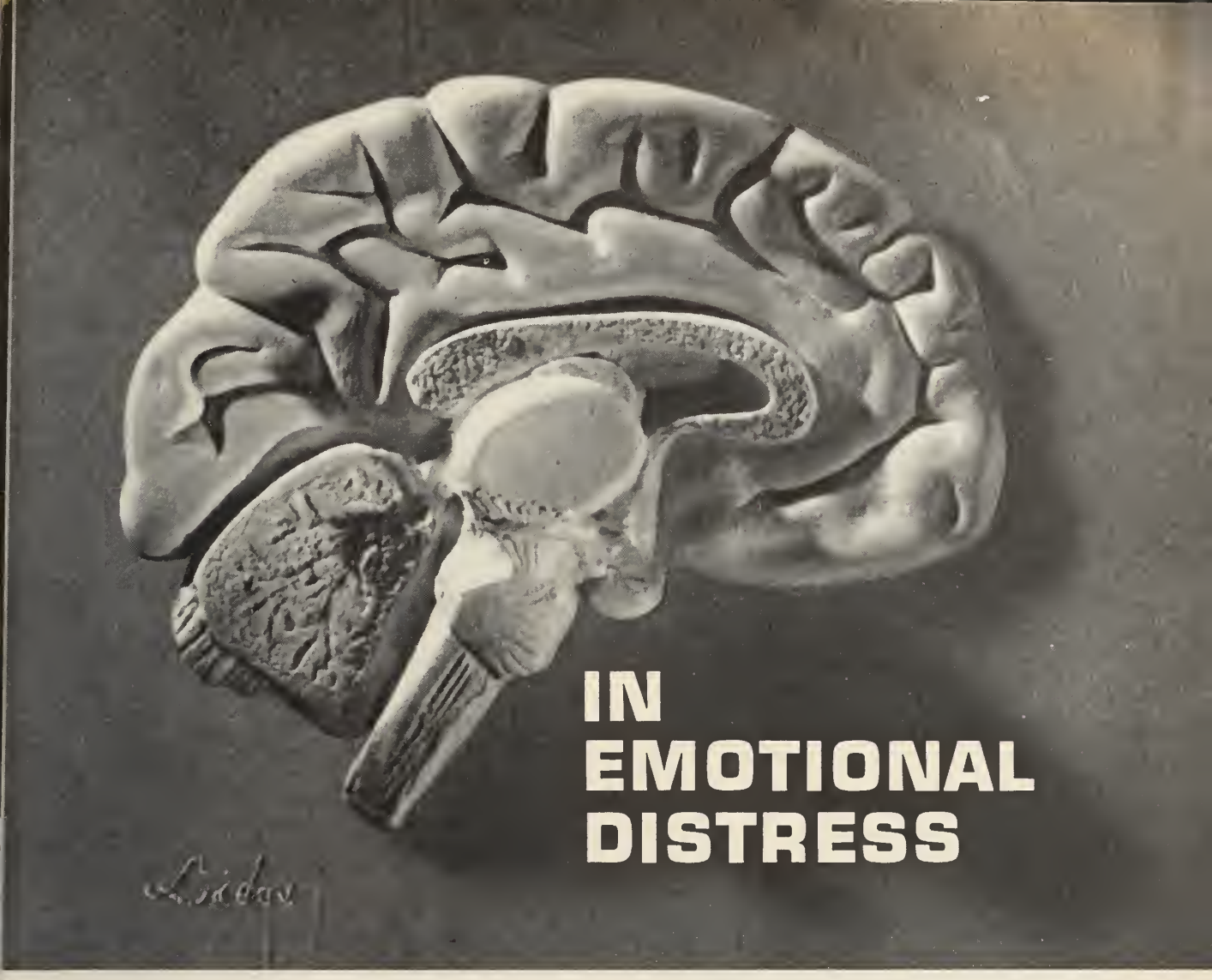
The Michigan Conservation Department is refurbishing the old buildings at the Fort, which was active

(Continued on Page 256)



Checks Presented

The AMA and MSMS at the County Secretaries-Public Relations Seminar presented checks totaling $84,204 to the two Michigan schools of medicine. A check for $52,216 was given to Dean William N. Hubbard, Jr., M.D. *(second from left)*, for the University of Michigan, and a check for $31,988 to Gordon H. Scott, Ph.D. *(at far right)*, vice president for medical school development, for Wayne State University. Joining in the ceremony were MSMS President Johnson, M.D. *(far left)*, and F. J. L. Blasingame, M.D. *(third from left)*, executive vice president of the American Medical Association. The $84,204 included money from several sources including contributions of $10 per Michigan doctor during 1963.



RELIEVES ANXIETY, APPREHENSION AND TENSION...



All day long

. . . keeps the patient calm, and the mind clear.



All night too

. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-1969

WALLACE LABORATORIES *Cranbury, N. J.*

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey
Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

Seek Equipment for Medical Dispensary at Fort Wilkins

(Continued from Page 254)

in the early mining period. The officers' quarters, furnished in the period of the time, is one of the popular summer attractions.

The old fort dispensary is in remarkably good condition, but is empty, according to W. W. Hassig, M.D., Detroit, who is keenly interested in the move to equip the dispensary.

Interested doctors may obtain further information from Doctor Hassig, medical director, Burroughs Corporation, Detroit; or from Alan Billings, Manager, Fort Wilkins State Park, Copper Harbor.

Doctor Hyland, State Chairman Of U. S. Committee of WMA

William A. Hyland, M.D., Grand Rapids, MSMS Treasurer, and head of the MSMS delegation to the AMA House of Delegates, has been appointed Michigan Chairman for the United States Committee, Inc., of the World Medical Association.

The state chairman is responsible for directing programs and activities of the U. S. Committee in his state and will urge physicians to join the U. S. Committee. The U. S. Committee, led by Austin Smith, M.D., president of the Pharmaceutical Manufacturers Association, is a special supporting unit of WMA. Edward R. Annis, M.D., is president of WMA.

AMA Convention to Offer New Info on Computer Use

MSMS members attending the scientific meetings at the American Medical Association convention in San Francisco, June 21-25, will be able to participate in an unusual session on "Computers in Medicine."

This interesting presentation on Thursday afternoon, June 25, will tell about the computer's potential role in detecting, amplifying, measuring, analyzing, correlating, communicating, controlling and forecasting the manifestations of patients.

The 113th annual AMA convention is expected to draw more than 15,000 physicians.

AMA-ERF Explains Projects Financed by Contributions

"Support the AMA-ERF which works with you to solve the problems to which you have dedicated your life."

That was part of the appeal made by the AMA-ERF

(Continued on Page 258)

SHEDD'S SAFFLOWER MARGARINE

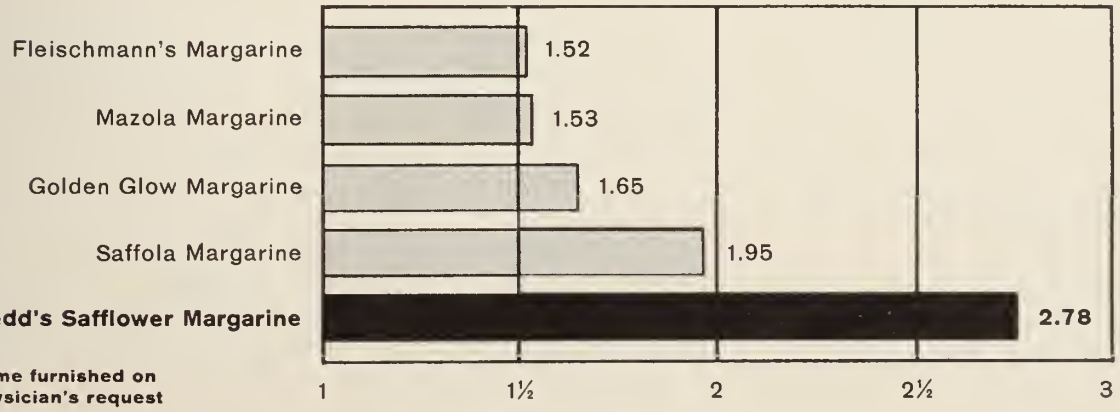


RATED BEST!!

in ratio of poly-unsaturates to saturated fats

An outstanding, independent research laboratory* was asked to compare five leading margarines for their proportions of beneficial poly-unsaturates to saturated fats. All samples were purchased at store level by shoppers for the research laboratory, and the results given are the average of two tests made on each margarine.

THE RESULTS OF THIS TEST PROVED SHEDD'S SAFFLOWER MARGARINE HAS A HIGHER RATIO OF POLY-UNSATURATES TO SATURATED FATS.



*Name furnished on physician's request

Shedd's Safflower Margarine Tastes Best, too!

NOTE TO DOCTORS: For free physician's certificates just send your request to Shedd-Bartush Foods, Inc., Detroit 38, Mich., on your Rx form.

AMA-ERF Explains Projects Financed by Contributions

(Continued from Page 256)

in a mail invitation to each physician recently. A letter from F. J. L. Blasingame, M.D., Executive Vice President of the AMA, explained the various projects financed by the AMA-ERF through contributions from doctors, families and friends.

Michigan Medical Meetings

April 13-17, Michigan Nurses Association Conference, Kellogg Center, East Lansing.
April 22, Western Michigan Trauma, Muskegon Country Club.
May 13, Michigan Chapter, American Medical Writers' Association, Michigan Union Club, Ann Arbor.
May 13, Mott Pediatric Symposium on School Health, Mott Foundation, Flint.
May 14-15, Michigan State Medical Society Maternal and Perinatal Mortality Workshop, Gull Lake Conference Center, Battle Creek.
May 20, Wayne State University Clinical Program & Alumni Reunion Banquet, Sheraton-Cadillac Hotel, Detroit.
May 21-22, Seventh Annual Children's Hospital Clinic Days, Wayne County Medical Society, Detroit.
May 23-24, Michigan Kidney Disease Foundation, Henry Ford Hospital, Detroit.
June 12-13, Upper Peninsula Medical Society Annual Meeting, Houghton.
June 14-16, Michigan Hospital Association, 45th Annual Convention, Grand Hotel, Mackinac Island.
July 30-31, Coller-Penberthy Clinic, Traverse City.
September 20-26, Michigan State Medical Society Annual Session, Sheraton-Cadillac Hotel, Detroit.
November 14-15, Michigan Allergy Society Midwest Forum, Ford Hospital Auditorium, Detroit.

Welcome, New Members

Edgar P. Balcueua, M.D.
1028 N. Bond Street
Saginaw, Michigan
Pathology

Gilbert M. Berman, M.D.
22100 Coolidge
Oak Park, Michigan, 48237

William D. Burton, M.D.
University Medical Center
Ann Arbor, Michigan
Pathology

Keith L. Curtis, M.D.
531 Foote Street
Charlotte, Michigan
General Practice

Maynard DeKryger, M.D.
828 Oak Street
Cadillac, Michigan

Herbert E. Dennison, M.D.
2604 Albert Drive, S.E.
Grand Rapids, Michigan 49506
Obstetrics-Gynecology Res.

John E. Doolittle, M.D.
1100 Sixth Street
Traverse City, Michigan
Obstetrics-Gynecology

Edwin H. Gullekson, M.D.
2024 Kingswood Drive
Flint, Michigan
General Practice

Henry V. Guzzo, M.D.
110 W. Division Street
Dowagiac, Michigan

John K. Hampshire, M.D.
Ypsilanti State Hospital
Ypsilanti, Michigan
Psychiatry Res.

Kent R. Hay, M.D.
1322 E. Michigan Avenue
Suite 112
Lansing, Michigan
Anesthesiology

Edward Lee Herman, M.D.
Pontiac State Hospital
Pontiac, Michigan 48053
Psychiatry

Nanette Jagnow, M.D.
525 Southfield Road
Birmingham, Michigan 48009
Pediatrics

Austin M. Katz, M.D.
Pontiac State Hospital
Pontiac, Michigan
Psychiatry

Edward G. Lievois, M.D.
289 Westbourne Drive
Birmingham, Michigan 48010
Roentgenology
Radiology

Donald C. Overy, M.D.
880 Woodward Avenue
Pontiac, Michigan 48053
Cardiovascular Diseases

Gerald D. Powell, M.D.
1515 West Mt. Hope Avenue
Lansing, Michigan
General Practice

Robert E. Shanahan, M.D.
Burns Clinic
Petoskey, Michigan

John A. Sheets, M.D.
Burns Clinic
Petoskey, Michigan

Mehdi Sherkat, M.D.
310 Sixth Street
Royal Oak, Michigan
Surgery

Marvin D. Silver, M.D.
Detroit Receiving Hospital
Detroit, Michigan

Milton F. Simmons, M.D.
12500 E. Twelve Mile Rd.
Warren, Michigan

Michael R. Stoyka, M.D.
8487 Kenny
Detroit 34, Michigan

Robert Teahan, M.D.
50500 Mound Rd.
Utica, Michigan
Internal Medicine

Thomas D. Tierney, M.D.
950 East Maple Road
Birmingham, Michigan 48011
Psychiatry

George Wasty, M.D.
Sparrow Hospital
Lansing, Michigan
Pathology

Ronald J. Welcome, M.D.
Sparrow Hospital
Lansing, Michigan

Dale L. Williams, M.D.
1107 Hendricks Road
Muskegon, Michigan

B. David Wilson, M.D.
15428 Archdale
Detroit 27, Michigan

Melvyn D. Wolf, M.D.
20211 Greenfield
Detroit 35, Michigan
Orthopedic Surgery

Hackley E. Woodford, M.D.
599 E. Main
Benton Harbor, Michigan

Gustav A. Uhlich, M.D.
Burns Clinic
Petoskey, Michigan

Mercedes A. Victoria, M.D.
108 Auburn
Pontiac, Michigan
Psychiatry

Ara Yarjanian, M.D.
3815 Pelham Rd.
Dearborn, Michigan
Surgery

Norman Zucker, M.D.
27225 Little Mack
St. Clair Shores, Michigan
General Practice

in maintenance therapy...

Arthralgen®

a working analgesic for the active arthritic



ARTHRALGEN®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

Arthralgen, a better-tolerated analgesic formulation of time-tested ingredients, works faster to free the arthritic from his pain without salicylate side effects. Since its analgesic components require no chemical conversion to act in the body, Arthralgen's pain relieving benefits are immediately available to provide a smoother, more rapid obtundation of pain than can be achieved with many true salicylates.

Arthralgen is especially useful for the prompt relief of early morning stiffness and pain with less risk of gastric irritation. And since Arthralgen contains no sodium it is safe for long-term use in arthritics who have other conditions which necessitate sodium restriction.

ARTHRALGEN®-PR

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.
Prednisone	1 mg.

The basic Arthralgen formulation plus prednisone is indicated for patients who require steroids. Prednisone has three advantages over cortisone, hydrocortisone, and ACTH. They are: (1) lack of sodium retention, (2) absence of increased potassium excretion, and (3) the unlikelihood of steroid-induced hypertension.*

Robins

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms, dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomylitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

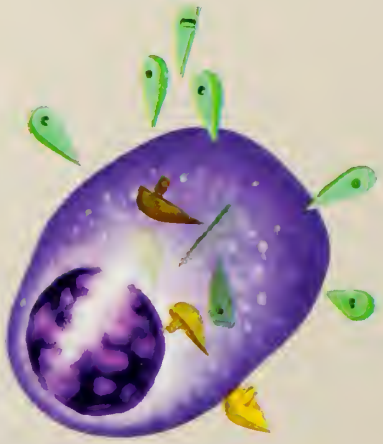
SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

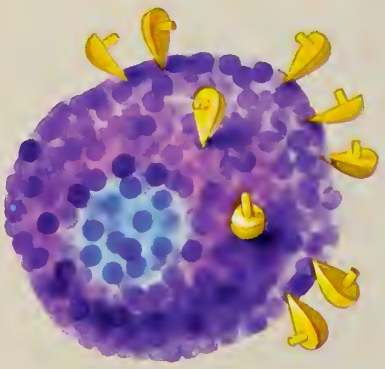
A. H. ROBINS CO., INC., RICHMOND, VIRGINIA

In theory, allergy works like this...

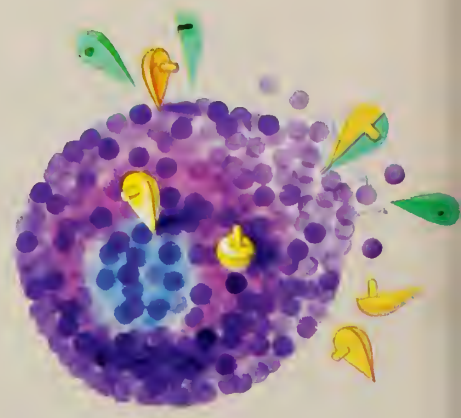
It is generally accepted that a complex antigen-antibody reaction underlies allergy. The reaction may be visualized in this simplified graphic form:



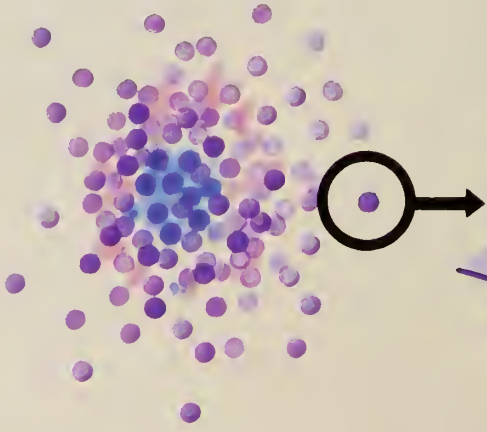
At first exposure to antigens (green) specific antibodies (yellow) are formed chiefly by plasma cells.



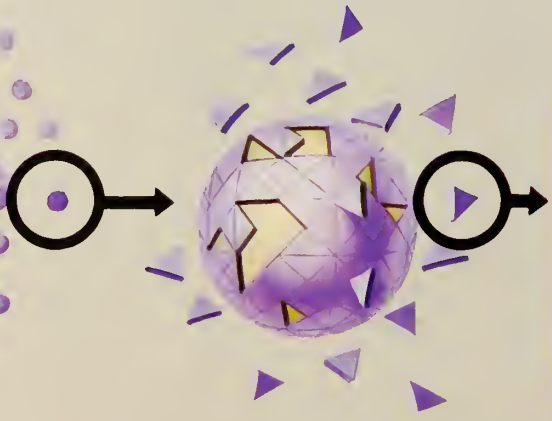
Circulating antibodies in the blood stream may become attached to mast cells in the tissues.



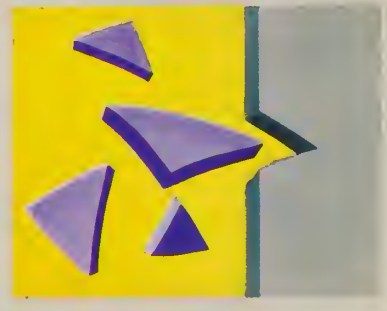
If the same *antigen* again enters the body and reacts with *antibodies* attached to cell walls, disturbances occur. The cell disrupts...



...depositing granules containing bound histamine or histamine-like substance in intercellular spaces.



Calcium ions and enzymes act on the granules breaking the binding and releasing histamine or histamine-like substance.



Theoretically, this liberated histamine (purple) acts at *receptor sites* in target tissues resulting in allergic manifestations.



Antihistamine (orange) is believed to compete with histamine at the receptor sites in target tissues – thus counteracting allergic effects.

In allergy, this antihistamine works with no more sedation than placebo*

The therapeutic response to Dimetane (brompheniramine maleate) is eloquent proof that a *potent* antihistamine does not have to be a sedative, too. You may expect unsurpassed relief of symptoms promptly in most types of allergy because Dimetane (brompheniramine maleate) *works* with a very low incidence of side effects. Indeed, as shown in a double-blind crossover study, with no greater incidence of sedation than placebo.*

*Schiller, I. W. and Lowell, F. C.: New England J. Med. *261*:478, 1959.

CONTINUOUS ACTION UP TO 10-12 HOURS

Dimetane® Extentabs®

(brompheniramine maleate, 8mg. & 12mg.)

BRIEF SUMMARY: Indications: Dimetane (brompheniramine maleate) is a potent antihistamine effective in a wide variety of allergic states.

Side Effects: Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia, have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, or giddiness may be encountered. Dryness of the mouth and mydriasis have been reported infrequently.

Precautions: Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

ALSO AVAILABLE: New lower strength Dimetane *8 mg.* Extentabs (brompheniramine maleate 8 mg.); conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA



an easier way?

'METHEDRINE'® brand
METHAMPHETAMINE HYDROCHLORIDE

is an easier way to help control food craving & keep the reducer happy

With "hunger pains" abolished, the patient can shrug off the chains of psychogenic craving that bind him to his habit of overeating and cooperate cheerfully with the prescribed diet.

In obesity, "...our drug of choice has been methedrine (methamphetamine hydrochloride)...because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West. J. Surg. **59**:238 (May) 1951.

Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

Dosage: 2.5 mg. (½ tablet) 3 times daily. May be increased gradually according to response; more than 10 mg. daily rarely is needed. The last dose of the day should not be taken later than 6 hours before bedtime.

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

Supplied: Tablets 5 mg., scored, in bottles of 100 and 1000.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Varied Projects of County Societies Serve Public

Members of the various county medical societies are always interested in the projects of other county medical groups. Often a project can be adapted and conducted in another part of the state.

Many projects are being conducted by component county societies to serve the public, according to articles appearing in Michigan newspapers.

Following are some brief digests of county society activities . . .



HURON STRESSES TETANUS IMMUNIZATION

The Huron County Medical Society is conducting a three-month tetanus immunization campaign. All members of the society are cooperating. Posters and news articles urge both children and adults to be immunized.

IONIA-MONTCALM OFFERS X-RAYS

Promotional efforts during February by the Ionia-Montcalm County Medical Society urged residents to get a free chest x-ray for tuberculosis, enlarged heart and lung cancer. Other health and civic groups cooperated.

KENT BACKS "WITHDRAWAL SCHOOL"

The Kent County Medical Society joined the Kent County Unit of the American Cancer Society to sponsor a "Withdrawal School" for smokers. The weekly sessions were limited by the 300-seating capacity of St. Mary's Hospital Xavier Hall.

OAKLAND HELPS SCREENING EFFORT

The Oakland County Medical Society was one of the cooperating groups during the tuberculosis and diabetic screening program during March at various Oakland industrial firms.

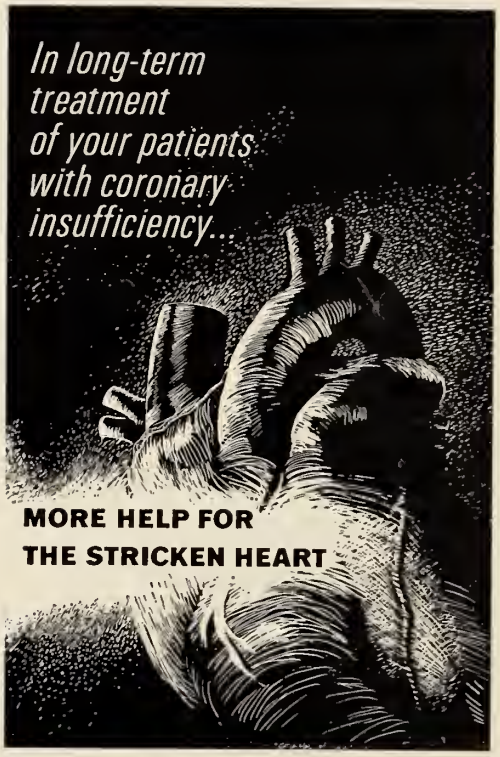
Factory personnel participated on a voluntary basis, with all suspect conditions referred to their own personal physician for follow-up investigation, diagnostic procedures and treatment.

Working together in the project were the medical society, the Michigan Diabetes Association, and the Oakland and Michigan health departments.

BARRY SUPPORTS HOSPITAL NEED

Members of the Barry County Medical Society adopted a resolution backing the Pennock Hospital emergency campaign to raise $600,000 for the expansion of the institution's facilities and services.

The Pennock Hospital trustees have inaugurated a drive for the



■ PETN (pentaerythritol tetranitrate) to increase oxygen supply

■ plus meprobamate to decrease anxiety and tension

Unlike phenobarbital, meprobamate is *not* cumulative and does *not* cause depression.

Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. **Precautions:** Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. **Contraindications:** Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* **Dosage:** 1 to 2 tablets, *before meals* and at bedtime. Individualization required. **Supplied:** Bottles of 50 tablets.

CML-1055

MILTRATE®

meprobamate 200 mg. + pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

Varied Projects Of County Societies

(Continued from Page 263)

$600,000 for a scheduled $750,000 expansion program to increase the bed capacity from the present 82 beds to 105, and to include a new pediatric unit, and to expand and relocate prime ancillary facilities.

MSMS OFFICIALS VISIT LIVINGSTON

The Livingston County Medical Society recently observed an "MSMS Night" when O. B. McGillicuddy, M.D., Lansing, President-Elect, and Bradley M. Harris, M.D., Ypsilanti, Councilor, spoke.

During the meeting, the Livingston County Medical Society discussed problems of mass casualty care.

Muskegon Trauma Day Soon

The fourth annual Symposium on Trauma will be presented by the Muskegon County Medical Society and the Muskegon Chapter of the Michigan Committee on Trauma of the American College of Surgeons, April 22, at the Muskegon Country Club. The formal program will begin at 1 p.m. A series of speakers will be offered from 1 p.m. to 5:30 p.m., followed by dinner at 6 p.m. and an address at 8 p.m. on Automobile Safety Engineering by a Ford Motor Company official.

Covering various trauma subjects will be Robert W. Bailey, M.D., Wayne W. Glas, M.D., and Robert E. L. Berry, all of Ann Arbor; George R. Daicoff, M.D., John H. Schneewind, M.D., Robert J. Freeark, M.D., and Nicholas Wetzel, M.D., all of Chicago.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

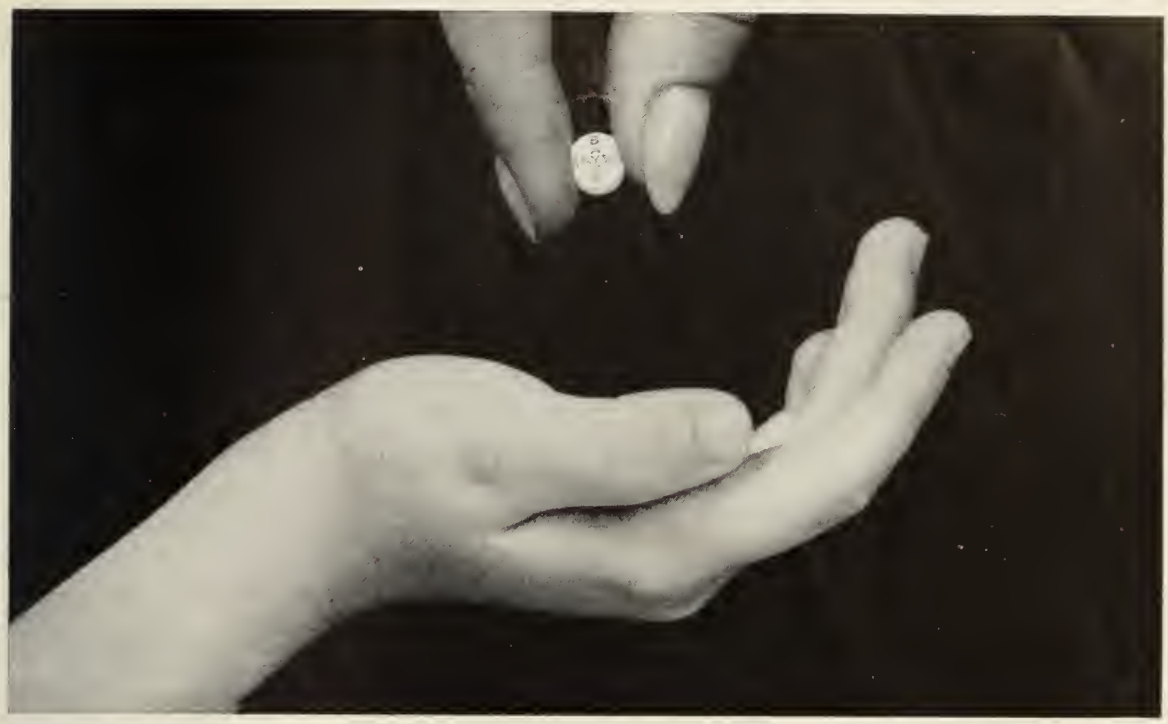
- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.



HOW TO BE SURE
your young patients get the aspirin dosage you want them to have

The answer is Orange Flavored Bayer Aspirin for Children

The dosage is 1¼ grains per tablet. Mothers place such confidence in the Bayer name. And the new orange flavor is so fresh and smooth that children take it readily. (The grip-tight cap on the bottle helps keep them from taking it on their own.)

For professional samples, just write The Bayer Company, Dept. 112, 1450 Broadway, New York 18, New York.





The discharged mental patient . . . and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. *27*:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

SK&F *Smith Kline & French Laboratories*

Say you saw it in the Journal of the Michigan State Medical Society



TRAUMA!

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Per Cent of Aged Covered By Health Insurance Climbs

By Richard M. Campau
MSMS Research Director

Approximately 75 per cent of the aged have available the means of meeting health care costs either through private health insurance or existing government programs, according to the Health Insurance Council. Some 60% of the nation's over age 65 population have some form of private health insurance, while approximately 14% are eligible under the Old Age Assistance Act and the Kerr-Mills Law.

Of 13 million senior citizens in the United States in 1952, 3,400,000, or 26.3 per cent were insured. By the end of 1962, our over 65 population had grown to 17,300,000 and 60 per cent of this age group were enjoying the benefits of voluntary health insurance. The spectacular growth of voluntary health insurance coverage—some 202%—suggests that the problem of providing adequate health insurance protection for the aged is well on its way to solution through voluntary private means.

There are several contributing factors to this phenomenal growth: Among them are:

1. The continuation of insurance on older active workers and their dependents under group insurance plans. It is the general practice of insurers to permit those who are employed beyond age 65 to remain insured on the same basis as younger active workers.

2. The continuation of group insurance on retired workers and their dependents, generally with part or all of the premium paid by the employer.

3. The continuation on an individual policy basis of coverage originally provided by group insurance, by virtue of the right of the employee to convert his group insurance coverage at the time of retirement.

4. The issuance of group insurance at advanced ages. Several insurers have written coverage on groups of persons already retired. These include groups such as the American Association of Retired Persons, associations of retired teachers or retired civil servants, or Golden Age clubs. Such protection is usually available without reference to current health status, and after a reasonable period of time provides coverage for recurrence of previously incurred illness.

5. Continuation of individual insurance purchased in the younger years into the later years of life. Today, most insurers do not terminate or reduce benefits under individual contracts when the insured attains age 65. Many such contracts are guaranteed renewable for life, while in others the insurer restricts its right to refuse renewal because of deterioration of the health of the insured.

6. The new issuance of individually purchased policies at advanced ages. This method of making coverage available to senior citizens has been an essentially notable innovation. There was a very general awareness among the aged of the need for health insurance. Thus, when coverage was offered at a reasonable premium and with few restrictions, a very large percentage of healthier older persons secured it.

7. Extending coverage to the aged by issuance of insurance that becomes paid up at age 65. The concept is that of enabling the policyholder to purchase lifetime protection during his productive years when income is customarily greater.

The Health Insurance Association predicts that by 1969, at least 80 per cent of the aged needing and wanting health insurance will have it—barring interference by government. By 1979, it is estimated this number could well increase to 90 per cent.

Says Federal Regulations Slow Down Development of Drugs

The food and drug amendments of 1962 have slowed the development of new drugs "to a mere trickle," declared E. Gifford Upjohn, M.D., chairman of the board of The Upjohn Company, at a recent regional meeting of the Pharmaceutical Manufacturers Association in Chicago.

Doctor Upjohn was critical also of the "destructive or punitive legislation aimed at the industry" concerning costs of drugs in foreign countries.

"We must make it clear that this condition exists not because the drugs are overpriced but because the people don't have money for the essentials of life."

Nor would less costly drugs alone assure adequate medical care, he said.

"The problem is much more complicated than that. Even if these people get the drugs for nothing, in order to use them effectively more hospitals, clinics and medical personnel would be required."

One appropriate course of action, suggested Doctor Upjohn, is to help give greater emphasis in the Alliance for Progress—which to date has emphasized housing—and other foreign aid programs to construction of hospitals, clinics, and various health training facilities and to the training of personnel.

THE ARTHRITICS WHO COULD NOT TAKE STEROIDS

The bane of the steroids, new and old, has been that certain undesirable metabolic effects—including salt and water retention, edema, overstimulation of the appetite, excessive weight gain, mood swings—seemed to be firmly linked to the primary anti-inflammatory action. For arthritics already overweight, or with cardiovascular disease complicated by edema, or those who were tense and anxious, steroid treatment could aggravate their problems. But with the advent of ARISTOCORT® Triamcinolone, many of these arthritics became "steroid-treatable." The reason: Not only did *this* steroid provide gratifying relief of inflammation and pain, but it did so *without* the penalty of overstimulation of the appetite, excessive weight gain, salt and water retention, edema, and undesirable euphoria. Six years of widespread use has confirmed these benefits for other arthritics as well as those formerly untreatable.



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Uropsychiatry

Functional complaints frequently center around the genito-urinary tract. Recognition is important to direct proper treatment and to avoid unnecessary surgical procedures. An evaluation of the entire patient is important in diagnosis. Careful and often time-consuming interview may be required. Snap judgments based solely on laboratory or x-ray findings should be avoided. At times the urologist must be his own psychiatrist and some examples from the author's experience are presented.

William J. Engel, M.D.
Cleveland, Ohio

IN EVERY FIELD of medical practice some knowledge of the patient as a total person is necessary for proper diagnosis and management. Thus, personality study and evaluation are equally important as laboratory studies or roentgen examinations. The psyche and the soma make up the total person, and the role of the psyche in producing disorders of body organ function has been long recognized, yet is sometimes overlooked by the busy clinician. Recognition of functional disorders is particularly important in the surgical specialties, and disorders of this type occur frequently in urologic practice. Recognition is essential if one is to avoid operations that are unnecessary, and which may in fact aggravate the "disease." The problem is compounded at times by the demonstrated presence of some abnormality that may or may not be the cause of the symptoms. The purpose of this paper is to discuss some of the features of the medical survey which may assist both the general physician and the urologist in recognizing the patient who has primarily functional disease.

Anxiety State

Even though we approach the realm of the psychiatrist, we should make some inquiry into the mechanism of functional disease. The anxiety state is the root of psychosomatic disorders. This state implies that there is a real or an imaginary threat to the individual's physical, social, or financial security; it may be some threat to a person's pride or ego; or there may be some great frustration or conflict between one drive and another in any individual. The result is open anxiety or what we call tension. Anxiety has two elements: (1) a psychic component, and (2) a somatic component. The psychic component makes us aware that something is wrong, and the somatic component is the actual motor response to various organs of the body; responses such as rapid heartbeat, rapid breathing, sometimes nausea or diarrhea, urinary frequency, as well as direct or referred pain that varies in degree and location.

The individual deals with open anxiety by various methods. One is suppression, by which one simply forces the problem out of the conscious mind and into the preconscious mind. However, it does not always stay there and may crop out and have to be suppressed again and again. In time, these emotionally loaded situations by some unknown process expend their energy on the autonomic nervous system and produce the familiar symptoms, of indigestion, palpitation, hyperventilation, frequency, and various types of



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smooth muscle pain. Any organ system may become the target in this psychophysiologic process we recognize as functional disease.

In some individuals, a second type of reaction occurs. This is repression and conversion. In this process, the problem is relegated to the unconscious area rather than the preconscious. In this situation, the patient forgets the problem, but this repressed energy is transferred or converted into something that is dramatic and appears to be a helpless infirmity. The response is converted into some voluntary mechanism such as paralysis of an arm, anesthesia of half of the body, stocking anesthesia, or even hysterical urinary retention.

A third type of reaction to anxiety is displacement. This may occur in the highly integrated intelligent patient, and manifests itself by phobias and compulsive reaction. The patient may have fear of cancer or some other such disease, and goes from physician to physician in search of reassurance or cure. His tensions are discharged by endless discussion of his fears to anyone who will listen.

True conversion neurosis is not commonly seen in urologic practice, but types one and three—suppression and displacement—are rather common. The real challenge to the urologic diagnostician comes in those patients who have some demonstrable or borderline abnormality that *might* account for the symptoms.

The family physician and the specialist in small communities may have some advantage in evaluating a patient because of their close personal acquaintance and knowledge of many of the factors that create functional symptoms. However, the urban consultant should exert every effort to gain some proficiency in this type of diagnostic ability. To do this, he must be willing to devote time for a careful, unhurried interview with the patient, and occasionally also with the relatives. Astute observation during the interview and physical examination may yield important information not revealed by any battery of laboratory or x-ray studies. Diagnosis is aided by establishing good rapport with the patient and may even require a survey of the patient's personality development. The physician must show a sympathetic understanding. The physician who shows signs of annoyance, or impatience, or criticism, or rejection of the patient's symptoms is wasting his own time as well as the patient's time and money. The surgeon who thinks solely in terms of operative therapy does not serve the best interest of the patient.

Fatigue is an almost everpresent associated symptom in patients with chronic anxiety tension. These patients are always tired, and as a characteristic feature of tension fatigue they are as tired when they arise in the morning as when they go to bed at night. Unlike physical fatigue, nervous fatigue is not relieved by a night's sleep. Although sleep brings loss of consciousness, activity at the unconscious level persists. Intestinal hypermotility may give rise to nocturnal diarrhea even with cramping pain. Nocturia may occur because of bladder stimulation.

Macy and Allen at the Mayo Clinic reviewed the records of 235 patients six years after a diagnosis of chronic nervous exhaustion had been made. The diagnoses proved to be 94 per cent accurate. It is also of interest that 289 separate operations had been performed on 200 of the patients included in their study.

Diagnostic Signs and Symptoms

Some of the features to look for are as follows:

(a) A well-nourished patient, complaining of pain with an almost satisfied look on her face. She has been told she has "trouble with the kidneys." Your index of suspicion rises if: six different physicians have already been consulted; these pains have been present for six years and no physician has pinpointed the cause; several operations have been performed without relief of the symptoms; the pain is shooting, stabbing "like a knife," or burning.

(b) Beware of the "it-seems-like" syndrome. A patient whose symptoms lack accurate description and "it seems like" the pain starts here then "it seems like" it moves over here, and sometimes "it seems like" it goes around, or "it seems like" it's worse in the morning and sometimes it's at night.

(c) A man whose wife sits next to the desk to give the history. Questions directed to the patient are answered only after he gains a glancing approval from his wife. One of his emotional difficulties is apparent.

(d) A young housewife who with two children is carrying on an outside job, while a baby sitter, often her mother-in-law, watches after the children. This patient has frequency, dysmenorrhea, backache, and has read in a magazine that these are often the symptoms of kidney trouble. Close inquiry may reveal that the husband works the second shift and his widowed mother lives with them.

(e) A rather precocious adolescent girl aged 14 to 16 years, who is brought in by a rather distraught mother. The young girl has a pain in the back, and it has been reported that albumin has been found in the urine. Previous radiographic study has disclosed evidence of ureteral kinking as a cause for the patient's pain. During the history it is revealed that there is fric-

tion between the daughter and her mother who has failed to realize that her child is growing up.

(f) A patient who brings out a piece of paper with all the symptoms noted on it, as well as a few questions to ask the physician. The French have given this syndrome the name "La maladie du petit papier." This is a warning of functional disorder. We have recently examined a patient who brought in 7 single-spaced typewritten pages covering her symptoms and various treatments. We would have to call this exhibition, to paraphrase in French: "La maladie du *grand* papier."

(g) A bachelor in the late thirties who complains of perineal pain he attributes to "prostated" gland trouble. Impotency may be an associated complaint, but questioning leaves uncertainty as to how this has been determined in the absence of feminine company.

(h) Exaggerated statements, such as "my kidneys are full of pus," made by a healthy ambulatory patient is a giveaway. Functional disease must also be suspected in the patient who uses medical terminology in describing the illness. When negative findings are reported to the patient, and she suddenly introduces a previously unreported complaint, this is indicative of functional disease.

During the examination, there are often telltale signs of functional disease. Deep sighing respiration may be observed, and the neurotic patient usually perspires excessively. Exaggerated response to palpation is almost pathognomonic. The patient jumps at the most gentle pressure and this hyperreaction becomes dramatic when one reaches the area of the patient's primary complaint. Hyperactive reflexes are usually demonstrated. Excessive modestly often characterizes the neurotic patient. Multiple surgical scars may be the badge of the functional patient, especially if one or more operations have been for "adhesions." Chewed finger nails and severely plucked eyebrows are added telltale signs.

In the conversion neuroses there may be a lack of concern or obvious anxiety regarding symptoms that are described as "terrible," "horrible," or "terrific pain." Even hysterical urinary retention does not seem to alarm the patient much, and often there is surprising absence of pain and discomfort that usually accompany an overdistended bladder.

With this brief introduction to the problem I would like to describe a few illustrative situations.

Illustrative Cases

A woman, aged 23 years, is examined because of pain in the right flank. The urinalysis is negative, but the intravenous urogram demonstrates a minimal pyelectasis with some retention of contrast medium in the 60-minute film. The wise surgeon will not immediately assign the symptoms to this abnormality, but will carefully evaluate the patient's personality, and upon inquiry will discover telltale symptoms of other functional disorders, and will learn something of factors that might create functional disease. In this patient such factors were elicited and no operation was advised. She returned several years later, and another intravenous urogram revealed no change in the degree of hydronephrosis. We have seen many such cases of nonsurgical hydronephrosis.

Renal ptosis has in the past been thought to produce flank pain, and even today there are enthusiasts who advise nephropexy. Increased mobility of the kidney, especially on the right side, is a common condition, and if the patient's pain is on the right side, there is a great temptation to say the ptosis is the cause for the pain. *In our experience, symptomatic nephroptosis is an extremely rare condition.* I am also impressed by the considerable number of patients we examine who have undergone nephropexy without relief of symptoms. Nephroptosis often occurs in the asthenic, tense, and tired patient, a type predisposed to functional disease. Therefore, careful uropsychiatric examination is indicated in any patient with nephroptosis, before considering operation.

Localized caliectasis may be demonstrated in a patient who has a nonspecific type of pain.

A few years ago I examined a 17-year-old girl who complained of bouts of pain in the right side, and it was reported that pus cells had been found in the urine. During the interview and examination the patent appeared tense, while a rather domineering and impatient mother gave most of the history and answered the questions. Intravenous and retrograde pyelograms revealed pronounced upper right caliectasis with some narrowing of the calyceal infundibulum and retention of contrast medium in the upper calyx. Urine collected from the right kidney was normal and the culture sterile. The question then arose—How much of this patient's symptoms are due to the caliectasis and how much is functional? Because there was more evidence in favor of the latter diagnosis, she was returned to her family physician for symptomatic treatment and further observation. Her symptoms persisted, sometimes necessitating absence from school, and on one occasion there was evidence of urinary infection with pyuria and a positive urine culture that responded well to antibacterial drugs. She was observed for more than a year, during which time an intravenous urogram showed the caliectasis unchanged, but her symptoms became more pronounced, and we finally performed partial nephrectomy with removal of the dilated upper calyx. Relief of symptoms was temporary but then returned, along with the additional complaint of some tenderness in the incisional scar.

The brief résumé of this case illustrates two other points: (1) that simple caliectasis usually produces no symptoms, (2) operating solely for pain is like wrapping up a wisp of smoke.

Can functional disease cause pain arising in the uri-

nary tract? It is well recognized that smooth muscle spasm of the intestinal tract can cause pain, and I believe the same can be true of ureteral spasm.

This was impressed upon me many years ago, when I operated upon a young woman who had had three previous operations for severe attacks of right lower quadrant pain. Examination had disclosed an accessory ureteral orifice on the right side, which would not admit a No. 4 ureteral catheter beyond 2 cm. Catheterization and attempts to inject contrast solution accurately reproduced the pain.

At operation, the accessory ureter was exposed, and active hyperperistalis was noted. The accessory ureter was traced upward and was found to end blindly at the level of the renal hilus. It was grossly and histologically a normal ureter, yet following its removal the patient had complete relief of symptoms and has remained symptom-free for these many years.

If such an apparently normal accessory ureter can produce pain, it is certainly possible for the normal ureter to do the same. In fact, I have always suspected that the once popular "ureteral stricture" was in fact nothing more than segmental ureteral spasm. When ureteral spasm or hyperperistalsis is suspected as the cause of pain, relief can usually be obtained with one of the anticholinergic drugs supplemented by generous reassurance.

The bladder is commonly the target organ in the neurotic patient. Almost, though not entirely, limited to women, the main complaint is urinary frequency. These patients are afraid to go out in public because of their embarrassing frequency. One young girl was almost afraid to have dates, for when a boy friend called and rang the doorbell she had to run to the toilet, and was afraid to go to the movies for fear she would be unable to control the urine. I believe the "irritable bladder" is a distinct entity quite similar to the "irritable bowel" with which the profession is more familiar.

Smith recently discussed what he terms "psychosomatic cystitis." He points out that there are three psychophysiologic mechanisms that may disturb bladder function: (1) acute spastic bladder reaction (irritable bladder), (2) variations in excretion of salt and water, and (3) functional polydipsia. The latter is aggravated by the dry mouth and throat which so often accompany tension.

In relation to acute spastic bladder reaction, he quotes the work of Straub, Ripley, and Wolf who recorded cystometric curves during psychiatric interviews. With ordinary conversation, no changes occurred, whereas marked increase in bladder contraction was noted when the subjects discussed were those about which the patient was sensitive.

Exposure to stress causes widespread disturbance in the endocrine system. Smith cited the observation of Blomstrand and Lifgren that emotional stress could cause either diuresis or antidiuresis. These workers showed experimentally that ischemia of the renal cortex occurred with emotional stress, presumably because of an increase in the secretion of epinephrine. There is also evidence that emotional stress acts through the hypothalamus to affect the secretion of antidiuretic hormone, thus causing diuresis or antidiuresis. Thus emotional stresses may in fact be psychochemical, and result in significant pathophysiologic alterations.

Although it is of scientific interest to speculate upon the causes of urinary frequency, from the practical point of view the important thing is to determine the basic fact of functional origin in order to avoid surgical procedures. In women there has been a temptation to recommend bladder neck resections, which often fail to bring relief, and moreover we have been called upon to repair a urethrovaginal fistula resulting from such an operation.

Functional frequency may also occur in the male, and may mistakenly be diagnosed as vesical neck obstruction for which transurethral resection is performed. Not only does such an operation fail to relieve these men but the symptoms and disability may become accentuated.

Treatment

What does one do with these functional urologic problems? When the diagnosis is established the problem must be explained to the patient in terms he can understand. Most important is to emphasize the point that you know the trouble is real and not imaginary; that disturbed function can make a person ill, but it cannot be surgically removed and discarded. To the mechanically oriented patient, the problem can be likened to the motor car in which the timer is malfunctioning. There is nothing wrong with the engine, but it "won't run." I have found it helpful to tell these patients that they have two nervous systems. One is under their control and provides the mechanism for voluntary muscular activity. The other is the automatic (autonomic) nervous system over which they have no control but it is under the strong influence of the emotional brain centers. Thus emotional stresses, some even unknown to the individual, can cause aimless and disturbing impulses to be discharged over this automatic nervous system. The result is a very real illness due to disturbed function, but this disease cannot be cut out and thrown into the pan like an infected appendix or an obstructing kidney stone.

Such careful explanation to the intelligent psycho-

neurotic who is capable of some insight into the problem, can yield gratifying results, and will repay the time spent. Your time will be wasted on some of the conversion reactions and incorrigible hypochondriacs, who in all probability will seek another physician for more welcome advice, and all too often another operation.

Some patients require psychiatric or psychoanalytic treatment, but it is neither fair nor proper to send to the overburdened psychiatrist all the functional problems encountered in daily practice. Many times the specialist must become his own semipsychiatrist and, in fact, with his intimate knowledge of the negative findings after complete examination he may be in a better position to counsel the patient and give him the greatly needed reassurance.

In today's world, tension touches us all. The lay press is filled with medical and pseudomedical articles under the guise of health education. Instead of being health-conscious, the public has become disease-conscious. The psychoneurotic patient, already susceptible, reads these articles and hurries to the physician's office full of anxiety, and apprehension. If, as the figures indicated, thirty of every hundred patients admitted to the hospital, and 60 per cent of the patients consulting a physician have functional problems, it well behooves the physician as well as the specialist to learn to recognize these patients, and to make sure that they receive proper medical advice. Surgery at the present time is under some criticism for what some regard as unnecessary operations. Modern anesthesia and supporting care has increased the safety and recovery rate of most surgical procedures. However, recovery from an operation does not necessarily carry with it "cure" of the patient. In recent years there has perhaps been a tendency for surgical techniques to receive greater emphasis than surgical judgment. Since the patient with functional disease may actually be made worse by even the most skillful operation, surgical results and the fair name of surgery will both be enhanced by the recognition of functional disease and providing for it the skillful professional care that it requires.

Survey Finds 30 Per Cent Short of Breath

An intensive survey of postal workers in Detroit indicates nearly 30 per cent of those over the age of 40 suffer from shortness of breath.

Other respiratory diseases were found to be prevalent.

The study, directed by E. Osborne Coates, Jr., M.D., and George Bower, M.D., of Henry Ford Hospital, was made possible through Christmas Seal funds provided by the Michigan Tuberculosis and Respiratory Disease Association and the TB and Health Society of Wayne County.

It was the first survey of its sort conducted in Michigan in an effort to determine the prevalence of chronic respiratory diseases.

A total of 1,584 individuals over 40 years of age completed interviews and tests administered through the facilities of the Wayne County Society and the Detroit Department of Health. A temporary staff of five persons—two nurses, a medical technician, a social worker and a clerk—worked as a team under Drs. Coates and Bower to conduct the survey. Equipment utilized included the TB and Health Society's vitalometer for measuring lung capacity.

Of the group, 1,342 were males and 242 were females.

Respiratory function deficiency, based on four criteria, was found as follows:

* 13 per cent showed cough and/or phlegm
* Wheezing was detected in 25.1 per cent
* 19.4 per cent had high sputum (2 cc or more)
* Shortness of breath was detected in 29.8 per cent

Only those with regular daily symptoms of cough and/or phlegm for a period of three months each year, thus considered to have significant chronic bronchitis, were listed in this deficiency category.

Under a prior agreement reached with the public health committee of the Wayne County Medical Society, 129 employes (8 per cent) found to have suspected respiratory abnormalities were referred to their private physicians. Two of these also had positive chest x-rays and were hospitalized as new active tuberculosis cases.

The Laboratory And Anticoagulant Therapy

Laboratory methods employed for the control of oral anticoagulant therapy are relatively simple procedures that require considerable knowledge of the blood clotting mechanism for interpretation. The physician's ability to properly apply the results of the assays is dependent upon his familiarity with technical aspects of the tests.

At present the one-stage prothrombin assay of Quick is commonly used as a measure of controlling therapy. This procedure is dependent upon the interaction of a number of clotting factors including fibrinogen, prothrombin, Factor V, Factor VII and Factor X. It is not influenced by Factor IX, a substance depressed by coumedin and related drugs. Reagent strength and the ability of the technician to select a consistent end point are also factors of significance. Standardization of the procedure is often difficult and results should be correlated with clinical findings.

John A. Penner, M.D.
Ann Arbor, Michigan

DURING the past three years a program of lectures and laboratory instruction in prothrombin assay techniques has been offered at The University of Michigan under the auspices of the department of Postgraduate Medicine, the Anticoagulant Unit of the department of Internal Medicine and the Simpson Memorial Institute. The Michigan Heart Association was responsible for initiating this program and has continued to support it.

This project was developed for the purpose of improving the laboratory control of anticoagulant therapy. These courses have emphasized theoretical as well as practical aspects of coagulation and have provided laboratory personnel with the opportunity of evaluating and standardizing coagulation techniques.

A program such as this is limited in its ability to influence the use of anticoagulants since much of the information provided in the course is not immediately available to the physicians directing therapy. The physician may be unaware of the limitations of the procedures employed by the laboratory and lack the theoretical knowledge to fully understand and apply the assay results. Accordingly, the following discussion is presented to illuminate some of the theoretical and technical problems involved in the laboratory control of oral anticoagulant therapy.

From the Department of Internal Medicine (Simpson Memorial Institute), The University of Michigan, Ann Arbor, Michigan.

Doctor Penner is Established Investigator, American Heart Association; Research Associate, Simpson Memorial Institute; Assistant Professor of Internal Medicine, The University of Michigan.

Blood Coagulation

The rapid growth of knowledge in the field of blood coagulation has led to some confusion. The complexity of the system has increased markedly and terminology has become a problem. However, the basic reactions in coagulation remain relatively simple and consist of two easily separated events: (1) prothrombin activation to thrombin and (2) fibrin clot formation from fibrinogen. In the second reaction thrombin, the proteolytic enzyme formed from prothrombin, induces fibrin clot formation. As little as 1 per cent of plasma prothrombin activated to thrombin will produce a solid clot in a matter of seconds. Larger concentrations of thrombin will produce a clot almost immediately. Fibrin formation therefore appears as the initial thrombin is formed and does not reflect complete activation of prothrombin. The first reaction, prothrombin activation to thrombin, is the rate-limiting step for most

assays. A number of active factors from plasma platelets and tissue are responsible for initiating prothrombin activation and accelerating thrombin formation. These factors would seem to separate into two groups (Fig. 1). The tissue, or extrinsic group, of procoagulants include tissue thromboplastin, serum prothrombin conversion accelerator (Factor VII), accelerator globulin (Factor V), Stuart-Prower factor (Factor X) and calcium. A second independent system of activation is the platelet or intrinsic group of procoagulants and include platelet Factor 3, antihemophilic factor (Factor VIII), serum prothrombin conversion factor (Factor IX), accelerator globulin (Factor V), Stuart-Prower factor (Factor X) and calcium. As illustrated in Figure 1, both systems are capable of activating prothrombin to thrombin and both require two plasma factors (V and X) as well as calcium.

Oral Anticoagulants

The oral anticoagulants are primarily coumarin derivatives. They affect coagulation by reducing the activity of several procoagulants, prothrombin, Factor VII, Factor IX and Factor X. These factors are represented in both the extrinsic and intrinsic clotting systems and thus both systems will be affected by the action of the drugs. The actual mechanism of coumarin action is not well understood, although the antagonistic action of vitamin K is well established.

One-Stage Prothrombin Assay

The one-stage prothrombin assay of Quick[1] is the most frequently used method of controlling oral anticoagulant therapy. This procedure provides a measure of the extrinsic clotting system and is basically a thromboplastin clotting time in which equal volumes of thromboplastin, calcium and plasma are mixed. Clot formation is timed after the reagents are added to the plasma. The clotting time of the mixture will be influenced by a number of factors which can be listed as follows:

1. *Plasma*: Concentration of extrinsic plasma clotting factors including fibrinogen (I) and prothrombin (II).

2. *Reagents*: Potency of thromboplastin. Contamination of thromboplastin with plasma procoagulants and pH of the reagents.

3. *Technical*: Temperature of incubation, type and concentration of plasma anticoagulant, determination of end point and age of plasma.

The concentration of the plasma factors necessary for a normal one-stage assay varies. Single factors may be depressed to as low as 20 per cent of normal activity without affecting the test. If multiple factors

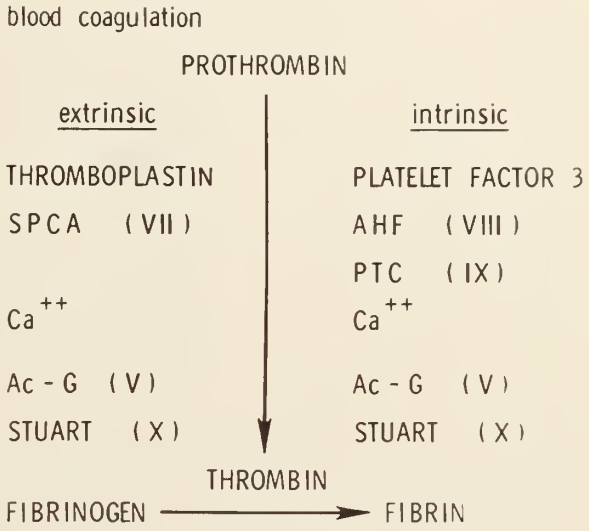


Fig. 1. Scheme of blood coagulation illustrating two systems of prothrombin activation.

are depressed an abnormal clotting time will result at somewhat higher concentrations. Fibrinogen, however, must be present in at least 40 per cent of normal to provide a normal clotting time by the one-stage assay.

Thromboplastin is a tissue lipoprotein of high molecular weight. It is prepared in crude form commercially from rabbit brain or lung and is usually combined with calcium in the final product. Blood products present in the tissue used for preparation may be a source of contamination with Factor VII.[2] Attempts at purification of thromboplastin have been unsuccessful and consequently the potency of each preparation may vary. The pH of the product will influence the clotting time. An optimal response is obtained at pH 7.2.[3]

Temperature must be maintained at 37°C during the assay. Fluctuations of several degrees will affect the clotting time significantly.

If plasma is assayed at intervals after venapuncture, the clotting time by the one-stage assay will be found to change; decreasing at the end of one hour and gradually increasing after four to six hours.[3] The type of anticoagulant used will affect this pattern. A plasma prepared with sodium citrate appears to be less variable than one containing oxalate.[3] Heparin will interfere with the assay and should not be used. Blood speci-

mens obtained from anemic patients will have a greater proportion of plasma and hence the concentration of the added citrate or oxalate in the plasma will be decreased. The converse will occur with blood from

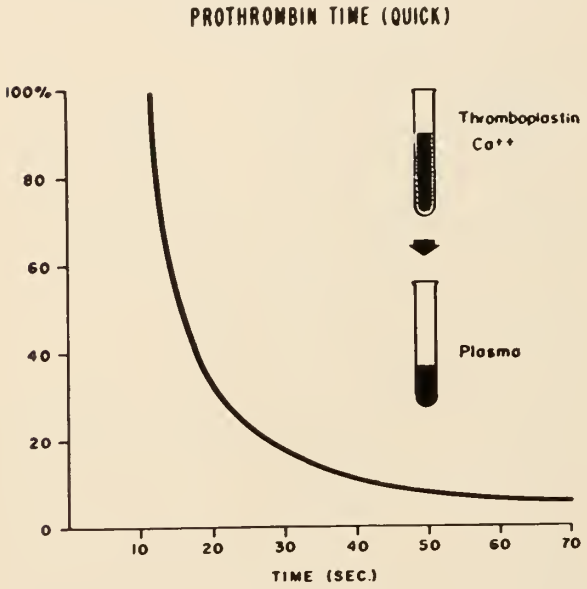


Fig. 2. One-stage prothrombin assay[1] with a standard plasma dilution curve.

polycythemic patients. The addition of fixed amounts of calcium to these specimens will not provide an optimal concentration and may result in delayed clot formation.

The precise determination of clotting time is difficult and technologists will vary in their ability to select a consistent end point. In our experience well-trained technologists using the same reagents and plasma will vary by as much as 20 per cent. If different reagents are employed, even greater variation is observed. The use of clot timing instruments may minimize this problem.

Standardization

Ordinarily a standard curve is prepared with each new lot of reagents. Pooled plasma or a dried commercial product is diluted with varying amounts of saline and assayed. The clotting time is then plotted against the plasma concentration as seen in Figure 2. The clotting time of an unknown plasma may then be translated into per cent of plasma concentration from the curve. It is standard practice to assay a normal undiluted control plasma daily as a means of checking reagents.

Several objections can be raised to this form of standardization and control. The control curve is based upon the clotting time of saline-diluted plasma which is not entirely comparable to undiluted plasma from patients receiving anticoagulants who lack variable amounts of several clotting factors. Plasma protein, citrate, fibrinogen and accelerator globulin (V) concentrations will differ. It is possible to dilute normal plasma with a plasma adsorbed with barium or aluminum salts that is deficient in prothrombin, Factors VII and X. Curves prepared from this mixture are more representative of the plasmas being assayed.

The shape of the curve should be examined. As seen in Figure 2 the first portion of the curve is steep. Only a few seconds separate the 50 per cent from the 100 per cent concentration. Interpretation of this portion of the curve is difficult even under optimal conditions. The midrange of the curve permits more accurate observations since the change in clotting time is of the same degree as the change in plasma concentration. The latter part of the curve is flat and clotting times beyond 45 seconds cannot be interpreted accurately in relation to concentration of plasma except to indicate that the concentration is less than 10 per cent.

The use of an undiluted normal or commercial control plasma will provide some information on the potency of reagents; however, the rapid clotting time of the undiluted specimen does not permit the demonstration of significant abnormalities which may be present at the more dilute or anticoagulant range. A control plasma prepared so that the clotting time remains in the anticoagulant range is most effective for evaluating reagents.

Significance of Results

The "one-stage assay" measures primarily the effects of limited amounts of Factors V, VII, and X on the rate of initial thrombin formation. Considerable reduction in Factors VII and X must be achieved during anticoagulant therapy before the test becomes abnormal. Factor IX, another procoagulant affected by the coumarin drugs, is not measured in this assay. Depression of this factor may be responsible for many of the complications that occur with therapy.

Actually the mechanism responsible for intravascular thrombosis has not been determined; and it is possible that the tissue or extrinsic system plays only a minor role in this process. Tissue thromboplastin is not found freely circulating and may only be released into the blood stream when tissue necrosis occurs. If this is the case, the intrinsic or platelet system of coagulation may be primarily responsible for thrombosis and the effectiveness of the oral anticoagulants would be related to

their action on Factors IX and X. A completely different form of assay would be necessary to measure both of these factors. Unfortunately, it would appear that the effect of anticoagulants on the intrinsic system does not always parallel the effect on the extrinsic system.[4] Consequently, an assay of one of these systems cannot be relied upon to provide information on the other.

Other Procedures

Several modifications of the one-stage assay have been described. The Ware assay[5] and Owrens P and P test,[6] for instance, require that the patient's plasma be diluted to produce a longer clotting time which would fall in the midrange of the normal plasma curve. Dilution is accomplished with adsorbed beef plasma which permits the retention of accelerator globulin (V) activity and fibrinogen. More recently Owren has described a procedure called the thrombotest[7] which combines elements of the one-stage assay of Quick and the partial thromboplastin time of Brinkhous.[8] This assay represents an attempt to measure both the extrinsic and intrinsic system of coagulation by providing a lipid platelet substitute and a weak thromboplastin. When both systems are activated optimally a clotting time of approximately 40 seconds results. Deficiencies of factors in either system prolong the clotting time. This thrombotest has been compared with one-stage assay[9] and may offer advantages in certain instances where anticoagulant therapy is difficult to control.

A capillary tube clotting time has been used successfully by Mayer.[10] This test would seem to provide a more direct indication of the effects of anticoagulants.

The thromboplastin generation test,[11] and the two-stage prothrombin assay[12] have also been effectively employed to control anticoagulant therapy.

Conclusion

Effective control of anticoagulant therapy requires that the clinician understand both the theoretical and the practical aspects of coagulation. The laboratory can only attempt to maintain consistent results and cannot provide data which are beyond the limits of the procedures employed. Nor can the laboratory interpret results with relation to the clinical condition of the patient.

The one-stage prothrombin assay, as it is employed in the control of anticoagulant therapy, provides information on several but not all of the factors depressed by the action of the oral anticoagulants. This assay is influenced by a number of technical factors and standardization often is inadequate. Results should be interpreted with respect to the shape of the standard curve, and with the understanding that they cannot always be correlated with the clinical state. The clinician must be alert to these facts and aware of the considerable variation in results that can be obtained under the conditions of the assay.

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Results of Uterine Cytologic Examination Of 29,302 Women Reported to a Cytology Registry in Metro Detroit

Results of the first uterine cytologic examination of 29,302 women reported to a voluntary cytology registry in Metropolitan Detroit revealed suspicious or positive (Class III, IV and V) reports in 862 women with no previous history of uterine cancer. Follow-up information was available in 708 (82.1 per cent) of these cases. In 476 women with tissue examination, 163 were reported to have cancer. This is 34.2 per cent of the women who had tissue examinations and 23 per cent of all the women for whom information was available. In addition, there were 24 cancers diagnosed in women with negative smears, making a total of 187 uterine cancers.

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IN 1957, a uterine cytology program was organized in the Metropolitan Detroit area, which was designed to encourage the use of the uterine and vaginal smear for the detection of uterine cancer. As part of this program, a Cytology Registry was developed for the purpose of collecting data on uterine cancer, for the evaluation of the smear reports and to assist physicians in recalling patients by sending reminders to them notifying them of the reexamination date. To carry out these objectives, physicians are requested to use a triplicate form furnished by the Registry and the pathologists who examine these smear specimens are requested to send the appropriate copy of this form to the Registry. A complete description of the program including a report of the preliminary results has been previously published.[1]

The object of this communication is to report the results of the first examination and the number of cancers diagnosed following this first examination in the 29,302 women whose examination reports were submitted to the Registry during the first three years of its operation (1958-1960). The greatest emphasis will be placed on those reports which were suspicious or positive (Classes III, IV, and V), since these reports are cause for concern to both patient and physician and, consequently, are usually followed by further investigative procedures.

ISIDORE SELZER, M.D.
The Author



Method of Study

The examination reports under consideration are the first reports of uterine cytological examinations recorded for these women by the Registry, but not necessarily the first uterine cytologic examination for any or all of these women. It is not known how many women may have had such examinations prior to our first report, but 151 of them have had a previous history of uterine cancer. Most of the 29,302 women

From the Michigan Cancer Registry, Detroit, Michigan. The Cytology Registry is a unit of the Michigan Cancer Registry.

TABLE I. DISTRIBUTION BY RACE OF 29,302 WOMEN EXAMINED AND OF POPULATION OF DETROIT METROPOLITAN AREA
1960 Census

Race	Total All Ages				20 Years and Over			
	Present Study		Population 1960 Census		Present Study		Population 1960 Census	
	Number	Percent of Total Known	Number	Percent of Total	Number	Percent of Total Known (20 & Over)	Number	Percent of Total (20 & Over)
White	27,634	95.3	1,612,601	84.7	26,345	95.4	1,001,591	85.6
Non-white	1,359	4.7	292,000	15.3	1,269	4.6	168,076	14.4
Not recorded	309	0	0	0	261	0	0	0
Total	29,302	100.0	1,904,601	100.0	27,875	100.0	1,169,667	100.0

were examined by their own physicians engaged in the private practice of medicine in the counties of Wayne, Oakland and Macomb and almost all of these women are residents of the three county area. Thirty-five per cent of the more than 600 physicians who participated in this program are engaged in general practice; 22 per cent limit their practice to obstetrics and gynecology; the remaining 43 per cent are part-time or full-time specialists in other fields. The laboratory specimens were examined and reported by 55 individual pathologists to whom the smear specimens were referred by the patient's physician.

The racial distribution of this group of women is indicated in Table I. This table clearly shows that the proportion of non-white women in this group is less than one-third of that found in the general population. The age distribution of this group compared to the general population is shown in Table II. There is a higher proportion of women in the lower age groups in this study than in the general population. This is true for both white and non-white women. The average age for white women 20 years and over in this group is 40.6 years and for non-white women 36.4 years.

The report form used by the Registry has been modified several times during the course of this project, chiefly in the section devoted to the report of the pathologist. However, in most reports referred to in this portion of the study, the classification used has been as follows:

Unsatisfactory, repeat smear
Negative
Atypical
Suspicious, repeat smear
Suspicious, recommend biopsy
Positive, request biopsy

This classification corresponds essentially to the original Papanicolaou classification, except that the last three categories corresponding to Papanicolaou's Classes III, IV and V include a specific recommendation for further investigation.

Information on the subsequent course of these women was obtained from two sources:

1. Repeat examination reports submitted to the Registry.
2. Replies to inquiries which are addressed routinely to physicians in all cases which are reported to be in Class IV and Class V and in all Class III cases in which a report of the recommended repeat smear was not received by the Registry.

TABLE II. DISTRIBUTION BY RACE AND AGE OF ALL WOMEN 20 YEARS OF AGE AND OVER IN PRESENT STUDY AND IN POPULATION OF DETROIT METROPOLITAN AREA
1960 Census

Age	White				Non-White			
	Present Study		Population 1960 Census		Present Study		Population 1960 Census	
	Number	Percent of Total Known	Number	Percent of Total	Number	Percent of Total Known	Number	Percent of Total
20-29	3,892	14.8	191,563	19.1	417	32.9	38,620	23.0
30-39	9,484	36.0	242,537	24.2	446	35.1	47,824	28.4
40-49	7,914	30.0	214,822	21.4	238	18.8	37,604	22.4
50-59	3,492	13.3	160,946	16.1	100	7.9	23,557	14.0
60-69	1,242	4.7	116,040	11.6	55	4.3	13,489	8.0
70-79	286	1.1	58,628	5.9	11	0.7	5,546	3.3
80+	35	0.1	17,055	1.7	2	0.2	1,436	0.9
Total 20 & over	26,345	100.0	1,001,591	100.0	1,269	100.0	168,076	100.0

TABLE III. RESULTS OF FIRST SMEAR EXAMINATION REPORTED TO CYTOLOGY REGISTRY FOR 29,302 WOMEN

Result	Number in Each Category	Number With Previous Diagnosis of Uterine Cancer	Total With No Previous History of Uterine Cancer
Positive (Class V)	108	5	103
Suspicious, recommend biopsy (Class IV)	359	11	348
Suspicious, repeat smear (Class III)	415	8	407
Atypical (Class II)	850	5	845
Negative (Class I)	27,313	122	27,191
Unsatisfactory for examination	257*	0	257
Total	29,302	151	29,151

*Includes four women whose reexaminations placed them in the Class III and Class IV categories.

The cases to be discussed will be divided into two groups—one comprising Suspicious or Positive (Class III, IV and V) cases, and the other, the Negative and Atypical (Class I and II) cases.

I. Suspicious and Positive (Class III, IV and V) Cases

There were 886 cases with a suspicious or positive result (Table III). Twenty-four women of this group had had a diagnosis of cancer made prior to their first entry into the Registry program and these reports will, therefore, be eliminated from the remainder of this discussion. For the remaining 862 cases, information is available in 708 cases (82 per cent) (Table IV). In about 6 per cent of the cases, no reply was received from the physician in response to at least two inquiries. In somewhat less than 12 per cent, the physician replied to the inquiry but the information received was of such nature that it did not contribute to further knowledge of the patient's course. This information consisted of such statements as "Patient moved," "Changed doctors," or "Did not respond." It is of interest to note that the higher the grade of suspicion, the greater the response. Thus, information is available on 97 per cent of the cases reported as Class V, contrasted with less than 73 per cent reported as Class III. The grade of suspicion also apparently influenced the choice of initial investigative procedure. When the report read—"Positive, Request Biopsy" (Class V), the physician followed this suggestion in about 88 per cent of the cases, whereas in the cases of "Suspicious, Recommend Biopsy" (Class IV), less than 74 per cent of the cases were so treated. At the other extreme, in 16 per cent of the cases in which only a repeat smear was recommended (Class III), a tissue examination was the initial follow-up procedure.

As far as the nature of the follow-up is concerned, the 708 cases with available information fall into three groups, all of which had a surgical procedure performed during some stage of the follow-up period.

Group 1—412 cases in which the tissue examination was the initial follow-up procedure.

This group is comprised of more than half of all the cases for which information is available. Tabulation of the type of procedure employed reveals that biopsy of the cervix alone or in combination with either D & C or conization or both was used 283 times or in more than two-thirds of the cases. D & C alone was only infrequently performed, and conization alone, even less so (Table V).

In this group there were 124 cases with a definite diagnosis of cancer, four cases of possible cancer, 33 cases with atypical cervical epithelium and 251 cases in which there was a diagnosis of a non-neoplastic condition such as cervicitis or squamous metaplasia.

TABLE IV. AVAILABILITY OF FOLLOW-UP INFORMATION AND TYPE OF INITIAL FOLLOW-UP IN 862* WOMEN WITH SUSPICIOUS OR POSITIVE SMEAR REPORTS AT FIRST REPORTED EXAMINATION

Results of First Reported Smear Examination		Cases Without Follow-up Information		Cases With Follow-up Information			
				Type of Initial Follow-up Procedure		Total Number with Information	Percent of Total Cases
Classification	Number of Cases	Physician did not Reply to Inquiry	Physician Replied—Information not Contributory	Repeat Smear	Tissue Exam.		
Positive (Class V)	103	1	2	10	90	100	97.1
Suspicious (Class IV)	350	13	27	53	257	310	88.6
Suspicious (Class III)	409	40	71	233	65	298	72.9
Total	862	54	100	296	412	708	82.1

*Includes two women each in Class III and IV, whose first smear specimens were unsatisfactory, but on subsequent examination were reported to be in these categories.

TABLE V. TYPE OF SURGICAL PROCEDURE EMPLOYED DURING VARIOUS STAGES OF INVESTIGATION, AND NUMBER OF CANCERS DIAGNOSED IN 476 WOMEN WITH TISSUE EXAMINATIONS

Stage of Investigation	Total Number of Tissue Examinations	Type of Surgical Procedure Employed									Cancers Diagnosed	
		Biopsy of Cervix	D & C	Conization	Biopsy of Cervix & D & C	Biopsy of Cervix & Conization	D & C and Conization	Biopsy of Cervix, D & C & Conization	Hysterectomy	Partial or Complete Excision of Cervix	Miscellaneous	Number of Cases	Per Cent of Tissue Examinations
When surgery was initial follow-up procedure	412	120	29	27	81	14	58	68	6	2	7	124	30.1
When repeat smear was initial follow-up procedure	64	11	1	8	15	1	8	13	3	3	1	27	42.2
When first surgical procedure in above 2 groups failed to reveal cancer	49	3	1	8	6	0	5	1	23	2	0	12	24.5
Total	525	134	31	43	102	15	71	82	32	7	8	163	34.2*

*Per cent of women with tissue examination.

Group 2—296 cases in which the initial follow-up procedure was a repeat smear followed in some of the cases by a tissue examination.

The results of the repeat examinations are tabulated in Table VI. More than two-thirds of these repeat smears were reported as Class I or II. Only 71 of the original 296 cases were again reported as either Class III, IV or V. Subsequent to the initial repeat smear, there is no additional information at this time for 167 of the 296 women. Sixty-four women had tissue examinations and 65 were followed with additional smears. The 64 tissue examinations resulted in a diagnosis of cancer in 28 cases, possible cancer in one, "cannot rule out cancer" in another and miscellaneous non-neoplastic conditions in 34 cases. The type of surgical procedure used in these cases (Table V) parallels those used in the larger group in which tissue examination was performed directly following the first smear examination. The 65 women who were followed only with additional smears had a total of 94 smear examinations reported. With three exceptions, all were in Class I or II. These three exceptions were in Class III and no further information is presently available for these women.

Group 3—325 cases from the above two groups in which the tissue examination was not diagnostic of cancer (Table VII).

No further information was available in 203 cases at the time this study was completed. Forty-five cases from group one and four cases from group two had a second tissue examination performed. This resulted in 12 additional diagnoses of cancer; 11 from group one and one from group two (Tables V and VII). The remaining 73 patients were followed only with additional smear examinations, most of which were negative (Table VII).

II. Negative and Atypical (Class I and II) Cases

In order to determine the total number of cancers diagnosed following the first reported examination, it would be necessary to include all the cases occurring following a report of a negative smear. It is, of course, impossible to establish immediately the true incidence of cancer in the group of patients with negative smears, since there is no indication for biopsy in these cases.

However, in all cases with Class I and II smears, the Registry sends the physician a "Reminder Notice"

TABLE VI. RESULTS OF SMEAR EXAMINATION IN 296 CASES WITH SUSPICIOUS OR POSITIVE SMEARS (CLASS III, IV & V) WHEN INITIAL FOLLOW-UP PROCEDURE WAS A REPEAT SMEAR

Results of First Reported Smear	Number of Patients With Repeat Smear	Results of Repeat Smear					
		V	IV	III	II	I	Unsatisfactory
Class V	10	5	1			4	
Class IV	53	2	14	5	3	28	1
Class III	233	6	23	15	20	168	1
Total	296	13	38	20	23	200	2

notifying him of the date on which to recall his patient for reexamination. The physician is requested to inform the Registry if reexamination is not being done and if so, the reasons for omitting the examination. In this way, the Registry obtains information about some patients with negative smears, for whom biopsy or other surgical procedure has been performed.

Of the 292 patients in this group concerning whom such information was obtained, the tissue examination was reported as demonstrating the presence of cancer in 23 patients within a period ranging from three days to 13 months between the report of the smear and the diagnosis of cancer (Table IX). One of the women had simultaneous cancer of the cervix and of the endometrium. The initial smear examination in these 23 women were reported as "Negative" (Class I) in 18 cases, "Atypical" (Class II) in three cases and "unsatisfactory" in two cases.

Included in this group of women are three cases in which there was actually a positive smear following the first negative report, but the time interval between the two examinations was so short (one, two and three days) that it was considered reasonable to include these three cases for the purpose of determining the number of cancers present in this group of women at, or shortly following, the first smear examination.

Discussion

As a result of the tissue examinations performed on 476 of the 862 women with a first report of a suspicious or positive (Class III, IV or V) smear, 163 (34 per cent) were reported to have uterine cancer, of which 152 originated in the cervix, 10 in the corpus and in one the site was not specified (Table VIII). This number represents 23 per cent of the 708 women for whose follow-up course information is available. When one considers only the Class V and IV cases, 33.9 per cent of the 410 cases in these two categories for whom information is available had a diagnosis of cancer at biopsy. In these same two groups, 37.3 per cent of the tissue examinations performed were diagnosed as cancer.

Because of the large number of pathologists (55) reporting these Class III, IV and V cases and the resulting variation in criteria for reporting smear results which undoubtetdly existed, it is difficult, if not impossible, to draw generally applicable conclusions from this study of the correlation of the smear results with the subsequent biopsy results. However, in view of the fact that 91 per cent of the cases in Class V and Class IV with available information had biopsies resulting in only 33.9 per cent with a diagnosis of cancer, it would indicate that at least some of the cases had been over-reported in the evaluation of the smear. Although some of these patients may still prove to have cancer, many of them undoubtedly will remain in the unconfirmed category. In the original Class III group, a little more than one-third of the patients followed had tissue examinations. On the basis of the results of the repeat smears reported in Table VI, it would seem adequate and safe to follow Class III cases with additional smears before resorting to biopsy. On the other hand, the presence of 24 women with cancer among the 306 women in Class III with follow-up information would indicate that some of the Class III cases were being under-reported.

The histologic diagnosis of the 24 cases of cancer found in the 23 women with Class I and Class II smears at first report are listed in Table IX. No information is available to account for the negative smear specimens in this case, but this finding was not entirely unexpected because of the well-known variation in the availability of exfoliated cells. Erickson[2] reported 31 cases of cancer following negative smears among the first 80,000 women examined in the Memphis-Shelby County (Tenn.) survey.

The 187 cases of uterine cancer reported, occurred in 186 women, of whom 175 were white and 11 nonwhite. These 187 cases, consisting of 163 cases diagnosed following Classes III, IV and V smear reports and 24 cases following Class I and Class II smear

TABLE VII. FURTHER DISPOSITION OF 325 CASES WITH SUSPICIOUS OR POSITIVE SMEAR REPORTS IN WHICH THE FIRST TISSUE EXAMINATION FAILED TO REVEAL CANCER

Results of First Reported Smear	Results of First Tissue Examination			Further Disposition									
					Followed by Second Tissue Examination			Followed by Additional Smear Examinations					
								Number of Examinations and Results					
									Cases with One Examination			Cases with Two Examinations	
	Number of Cases Examined	With Diagnosis of Cancer	Failed to Reveal Cancer	No Further Information	Number of Cases Examined	With Diagnosis of Cancer	Again Failed to Reveal Cancer	Total Cases	Unsatisfactory	Class I	Class III	Class IV	Class I	Class II
Class V	98	65	33	16	12	5	7	5		3	1		1	
Class IV	275	63	212	129	30	6	24	53	1	33		2	17	
Class III	103	23	80	58	7	1	6	15		9		1	4	1
Total	476	151	325	203	49	12	37	73	1	45	1	3	22	1

TABLE VIII. SITE AND HISTOLOGIC DIAGNOSIS OF 163 CASES OF CANCER REPORTED FOLLOWING A FIRST REPORT OF A SUSPICIOUS OR POSITIVE SMEAR EXAMINATION

Result of First Reported Smear Examination	Number of Cases in Study with Information	Number of Cases with Tissue Examination	Site and Diagnosis							Cancers Diagnosed		
			Cervix					Corpus	Carcinoma, not Specified Specified Cervix or Corpus	Total Number	Percent of Cases with Information	Percent of Cases with Tissue Examination
			Carcinoma In Situ	Carcinoma In Situ with Early Invasion	Invasive Carcinoma	Epidermoid Carcinoma Extent Not Specified	Adeno-Carcinoma	Adeno-Carcinoma				
Class V	100	98	46		17	3	1	2	1	70	70.0	71.4
Class IV	310	275	39	3	19	2	1	5		69	22.3	25.1
Class III	298	103	15		5	1		3		24	8.1	23.3
Total	708	476	100	3	41	6	2	10	1	163	23.0	34.2

TABLE IX. HISTOLOGICAL DIAGNOSIS OF 24 CANCER CASES DIAGNOSED FOLLOWING A FIRST REPORT OF NEGATIVE (CLASS I OR II) OR UNSATISFACTORY SMEAR EXAMINATION AND TIME INTERVAL BETWEEN DATE OF SMEAR EXAMINATION AND DIAGNOSIS

Site and Histological Diagnosis	Time Interval in Months					
	1 or Less	2	4	8	9	13
Cervix						
Carcinoma in situ	6	1	1*			
Invasive carcinoma	4		1			
Extent not stated	1					
Adenocarcinoma		1			1	
Fundus						
Adenocarcinoma of Endometrium	3		1	1		1
Mixed Mesodermal Tumor			1*			
Leiomyosarcoma	1					
Total	15	2	4	1	1	1

One patient with simultaneous neoplasms

reports, represent a prevalence rate of approximately 6.7 newly diagnosed cases per 1,000 women in the 20 years and over age group.

Of the total 187 cases, 168 were reported to be in the cervix, 18 were in the corpus and one was unspecified (Table X). This ratio of nine cervical to one corpus cancer is higher than the ratio cited by Hertig and Gore[3] and the estimate of Willis,[4] but it is within the range cited by Herbut.[5] The occurrence of cervical cancer in the younger age groups and that of endometrial cancer in the older age groups, corresponds roughly to the findings of Willis[4] and others that corpus carcinoma occurs, on an average, about eight years later than cervical carcinoma.

The 168 cases of cervical cancer include 108 which were in the *in situ* group; 49 which were invasive; seven cases of epidermoid carcinoma in which the extent of disease was not stated and four cases of adenocarcinoma. The 49 cases of invasive carcinoma include three cases which were reported as showing early or microscopic-invasion. Of the 164 women with epidermoid carcinoma of the cervix, 157 were white and 11 non-white. These 11 non-white women with carcinoma of the cervix represent all the non-white cases of cancer in this study.

In situ carcinoma of the cervix in this study is more than twice as frequent as invasive carcinoma. This holds true for the white women alone and for white and non-white combined. For the non-white women, the prevalence rates for *in situ* and invasive carcinoma are equal. However, the number of cases is perhaps too small to draw any definite conclusions. The prevalence rate for all of the epidermoid carcinomas of the cervix is 5.9 per 1000 for white and non-white women combined in the 20 years and over age group. The rate for non-white women alone is appreciably higher

TABLE X. DISTRIBUTION OF 187 CASES OF CANCER BY AGE AND HISTOLOGIC DIAGNOSIS

Age in Years	Total	Site and Histologic Diagnosis							
		Cervix					Fundus		Not Specified Cervix or Corpus
		Carcinoma In Situ	Carcinoma In Situ with Early Invasion	Invasive Carcinoma	Epidermoid Carcinoma, Extent not Stated	Adenocarcinoma	Adenocarcinoma of Endometrium	Miscellaneous	
25-29	19	17			1			1	
30-34	27	22		4	1				
35-39	37	25	1	8		2	1		
40-44	40	26	2	8	2		2		
45-49	20	8		8	2	1	1		
50-54	12	5		6			1		
55-59	10	3		2		1	4		
60-64	9	1		5			3		
65-69	6			2	1		2		1
70-74	4	1		1			1	1	
75-79	3			2			1		
Total all ages	187	108	3	46	7	4	16	2	1

TABLE XI. PREVALENCE RATE PER 1000 WOMEN 20 YEARS OF AGE AND OVER FOR 164 NEW CASES OF EPIDERMOID CARCINOMA OF CERVIX UTERI BY RACE AND EXTENT OF DISEASE

Race	Number of Women 20 Years and Over in Study	In Situ		Invasive		Extent not Stated		Total	
		Number	Rate	Number	Rate	Number	Rate	Number	Rate
White	26,345	104	3.9	45	1.7	4	0.2	153	5.8
Non-white	1,269	4	3.2	4	3.2	3	2.4	11	8.7
Total	27,614	108	3.9	49	1.8	7	0.3	164	5.9

than for the white, but again the number of cases may be too small to draw any conclusions (Table XI).

In situ carcinoma occurs at a somewhat earlier age than invasive carcinoma. Although the peak age for both types was in the 40 to 44 year group, the average age of the 108 patients with *in situ* cancer was 38.1 years; of the 46 patients with invasive cancer it was 48.3; of the three patients with microscopic or early invasion it was 40.3 years. Exclusive of the latter three cases, the average age of the patients with invasive cancer was thus slightly more than 10 years higher than the average age of the patients with *in situ* cancer. If these three cases are included in the invasive group, the average age is 47.9 years and the difference between *in situ* and invasive cancer is slightly less than 10 years. According to Hertig and Gore,[3] this 10-year age difference is one of the features that suggest that carcinoma *in situ* probably is the preinvasive stage of invasive carcinoma of the cervix.

Summary

In a cytology registry operated as part of a community uterine cytology program in Metropolitan Detroit, the first recorded vaginal smear examinations for 29,302 women yielded 862 cases of suspicious or positive smears in women with no previous history of uterine cancer. Follow-up information which is available in 708, or 82 per cent of these cases, revealed the presence of 163 cancers. An additional 24 cases of cancer were diagnosed in 23 women with negative smears. The prevalence rate of newly diagnosed cancers per 1000 women, 20 years of age and over, was 6.7 for all cancers, 5.9 for all epidermoid carcinomas of the cervix, 3.9 for *in situ* carcinoma of the cervix and 1.8 for invasive carcinoma of the cervix.

Acknowledgments

The Michigan Cancer Registry receives its financial support from the Michigan Cancer Foundation.

The author wishes to acknowledge the cooperation of the hundreds of physicians in the Detroit Metropolitan area whose voluntary participation in the Cytology Program provided the information from which the data in this paper is derived.

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Medical Maxims

Postmenopausal bleeding calls for cystoscopic investigation if there is any uncertainty as to its origin.

The physician should avoid treating his own nervous symptoms at the expense of the patient.

After withdrawal of steroids, the patient should be watched for at least a year because there may be little adrenal reserve to support him during illness or surgery.

In carbon monoxide poisoning, inhalation of 5 to 10 per cent carbogen eliminates the carbon monoxide faster and increases the availability of oxygen to the tissues.

After 45, the mortality rate rises 1 per cent per pound over the ideal weight.

—"711 Medical Maxims II" by W. S. Reveno, M.D., Publisher, Charles C Thomas, Springfield, Illinois

Human Infection Caused By Listeria Monocytogenes

Wallace Nichols, Jr., M.D. and Carl A. Gagliardi, M.D.
Lincoln Park, Michigan

IT APPEARS to most investigators working with Listeria monocytogenes that, as more is known of this ubiquitous organism, it may represent one of the world's most important zoonoses. It already ranks eleventh in economic importance of the veterinary diseases. Medical reports on this organism are relatively recent. It was first described in 1926 and the earliest medical summary being only 20 years ago.[1] Information about listerial diseases is usually found in the veterinary and European medical literature and only sparsely in the American medical literature. It is our purpose in this review to elucidate some of the information presently available on the organism.

Bacteriology

Listeria monocytogenes is a Gram-positive organism often discarded as a diphtheroid or a contaminant. It is not acid-fast nor does it have the polar bodies common to corynebacteria. It can be grown on most simple laboratory media. Information concerning chemical, fermentation and other reactions characteristic to this organism can be found in most bacteriology references. This bacteria can be grown at refrigerator temperatures but optimum growth is exhibited between 20° and 37°C. At 20°C. and at 37°C., its motility is characteristically tumbling. On nutrient agar, the colonies are translucent and dew-drop-like. On sheep blood agar, the colonies are surrounded by a narrow zone of beta hemolysis. Surface growth may be smooth or rough; however, most fresh or virulent strains are smooth.

We have had experience with the method described by Gray of identifying the organism after growth on clear media for 24 hours without CO_2, at incubator temperatures. The colonies are scanned using a dissecting microscope with indirect light. The colonies appear as a unique blue-green color and are distinctive enough to be identified in contaminated cultures. The use of fluorescent antibodies is being investigated and may prove to be a valuable adjunct in identification in tissue specimens, contaminated material and in situations where a few organisms are to be identified under unusual growth conditions.

Antigenically, listeria can be divided into five groups, 1, 2, 3, 4a and 4b. The types are neither host nor disease specific although types 1 and 4 (mostly 4b) are most common in North America and Europe.

When the organism is injected into rodents (and sometimes in man), it produces a monocytosis. This is caused by a lipid (monocytosis-producing agent) and is not related to the antibody producing fractions. The organism, without exception, is pathogenic to animals although the usual experimental hosts are the rabbit and mouse. Generalized infection can be produced by intravenous and intraperitoneal injection to both and by subcutaneous injection into the mouse. When instilled in the rabbit eye, it will cause a keratoconjunctivitis (Anton eye test). If the animal is pregnant, sepsis and involvement of the fetus will often result. Susceptibility to infection in animals is inversely proportional to age and is increased by systemic steroids or pregnancy.

General

The organism is widespread in nature and its distribution has no geographic barriers. It has been found in 33 animals, 16 birds, and a trout. It has been identified in spring water, stream mud, sewage, silage, fodder, unpasteurized and pasteurized milk. It can occur in the latent state in wild animals and birds and has been recovered from ticks, flies and mites. It can survive in fertile soil as long as 295 days. Aerosols are infectious and remain viable in the sunlight. Infected animals can excrete the organism in the milk, vaginal and cervical secretions, stool and semen. The overall epidemiology is not well understood.

Diseases of Man

It is our purpose here to discuss the various forms of human listeriosis and the similar conditions found in animals. Because of their similarity, we might as-

sume that experimental data on the spread in animals could be true in man. The disease classification used is as suggested by Seeliger.[2]

Meningitis

This is usually the most frequent form of human listeriosis. In the review of listerial meningitis in North America since 1954, Nichols and Woolley[3] found 123 cases with an overall mortality of 44.8%. The U. S. Public Health Service suggests that the true incidence is much greater than this.[4] Gray[5] recently claimed that 500 cases had been found in the U. S., half of whom were less than two years old. Seeliger's comprehensive review to 1957 covered over 150 cases of meningitis with a mortality of about 50% and 40 cases of meningoencephalitis with 75% mortality.[2] The greatest incidence seems to occur under one month of age and over 40 years. Many of the elderly cases were superimposed on chronic or debilitating illnesses, e.g., collagen disease, leukemia, terminal cancer, alcoholism, et cetera. In some, there was a history of animal contact, e.g., farmers and veterinarians. At autopsy, many of the neonates with meningitis had a generalized listeriosis (granulomatosis infantiseptica). The organism may be found in the maternal vaginal or cervical secretions tending to incriminate the perinatal period as the time of acquisition of the organism.

In animal medicine, infection of the central nervous system is common in the larger domestic animals called Circling Disease, Grass Tetany or Pseudorabies. It can be produced experimentally by introduction of the organism intranasally, orally, parentally, and possibly venereally. The surviving animals often appear "dumb" and have difficulty keeping up with the other animals. The pregnant ones are usually more susceptible to infection. The infected pregnant animal is usually asymptomatic with the organism lodging in the reproductive system from whence it may spread to the fetus.

Human listerial meningitis is clinically indistinguishable from other purulent meningitides with identical symptoms and laboratory findings except that the involved neonates do not show predisposing conditions. Gram-positive organisms may be found in stained spinal fluid but may not appear bacillary in appearance. The reported susceptibility of the organism to antibiotics varies although sensitivity to tetracyclines is nearly universal. Our experience at Children's Hospital of Michigan would indicate that early therapy with the combination of sulfadiazine, penicillin and chloramphenical gives excellent results with only two of 16 patients expiring and no survivor sequelae. Other investigators, however, have noted serious sequelae. Lang's survey[6] of brain-damaged children showed a high incidence of elevated serum listerial antibody titers. Some Russian investigators have noted psychotic disturbances in the survivors.[2]

Granulomatosis Infantiseptica

(Listeriosis of the Newborn)

This, the severest form of human listeriosis, and formerly called Pseudotuberculosis of the Newborn, was elucidated by Potel and Seeliger as listerial neonatal sepsis. Although it is more commonly reported in the European medical literature, granulomatosis infantiseptica (G.I.) rates with erythroblastosis, congenital lues and toxoplasmosis as one of the more common causes of neonatal damage and death.

If not stillborn, the infant will soon show the vague, indefinite symptoms found in any neonatal sepsis. Chest x-rays may show evidence of pneumonitis although the picture is similar to hyaline membrane disease and aspiration pneumonia. On physical examination, granulomas may be found in the posterior pharynx or evidence of meningitis may be found as a bulging fontanelle, meningeal irritation, et cetera. Because meningitis is usually present, most of the survivors are classified as Listerial meningitis.

At postmortem, multiple areas of focal necrosis are often found in the viscera including the liver, spleen, central nervous system, lymphatic tissue with occasional involvement of the adrenals and G.I. tract. The organism can be cultured from these areas of necrosis or from the meconium, blood, and cerebrospinal fluid antemortem. The amniotic fluid may be turbid or meconium-stained. The survival rates are low and are probably dependent on the rapidity of diagnosis and treatment.

Seeliger[2] suggests that some of the infected infants may develop their clinical meningitis at a later time or only display the resulting central nervous system damage (similar to Lange).[6] Dungal believes that permanent liver damage may be present in the treated infant which may ultimately result in chronic hepatitis or cirrhosis.

The organism probably originates from the mother spreading transplacentally to the infant. Whether the infant is infected via aspiration or infected amniotic fluid, spread through the cord or by vaginal contamination varies. Animal studies suggest that the period of fetal inoculation determines whether an infection results in stillbirth, abortion, neonatal sepsis or meningitis. Some of the mothers have a history of repeated abortions.

Typhoid-pneumonic Form

This generalized form of human listeriosis is also rarely reported in the American medical literature. The course and pathologic findings may be similar to granulomatosis infantiseptica, or the picture may be that of sepsis or pneumonia. Some of the patients have had animal exposure, steroid therapy or a coincident debilitating illness. A few cases of listerial subacute bacterial endocarditis have been reported. Probably more patients will be found with this form of listeriosis as bacteriologists cease regarding "diphtheroids" in blood and cerebrospinal fluid cultures as contaminants.

Cervico-glandular Form

This rare disease is characterized by localized infection of cervical or submandibular glands with or without suppuration. Clinically the disease is similar to mycobacterial or cat-scratch adenitis and in a few cases listeria has been found in mixed cultures with acid-fast organisms. Both surgical and antibiotic therapy is indicated.

Septicemic Form with Angina and Mononucleosis

Since the first report by Nyfeldt of the isolation of listeria in cases of infectious mononucleosis, investigators have tried to find a causal relationship. Throats, blood and lymph nodes were cultured and listerial antibodies were titered with inconsistent results. The inoculation of listeria into animals and man may result in a monocytic serologic response but heterophile antibodies are not usually produced.

It appears, therefore, that listeria, like toxoplasmosis, can produce a clinical picture similar to infectious mononucleosis with cervical adenopathy, fever, monocytosis, splenomegaly, angina, and often hepatocellular dysfunction without specific heterophile antibody production (poorly absorbed by guina pig kidney). Abortive forms may also occur. The prognosis of this disease is excellent and appropriate antibiotic therapy may be of some value.

Oculo-glandular Form

Some cases of the above may have accompanying conjunctivitis or listerial conjunctivitis may occur alone. One Soviet report[2] describes listerial conjunctivitis with enlarged parotid or submandibular glands and lymphocytosis. This form of Listeriosis may be caused by heavily contaminated dust or by rubbing the eyes with soiled hands. Felsenfield reported two chicken cleaners in a poultry shop developing listerial conjunctivitis.

Listeriosis During Pregnancy

The realization that listeria can be a virulent pathogen to the fetus transmitted by an asymptomatic pregnant female is provocative. The relationship has been well shown in animals, both naturally and experimentally. The world prevalence of the human form can only be surmised. Rappaport et al[7] reported 24 of 33 women with histories of repeated miscarriages were found to have positive cervico-vaginal listerial cultures while comparable cultures on 87 non-abortors were negative. However, Rabaci and David[8] had negative results with similar studies in the same country. Rappaport's repeated abortors with positive cultures were able to have viable births after antibiotic therapy.

The mothers of infected infants are usually asymptomatic or have vague symptoms. The organism tends to settle in the reproductive system spreading to the fetus in a degree dependent on its age. Listeria has been found in both raw and pasteurized milk but not as yet from human breast tissue or milk. Infection of the animal reproductive system may ultimately lead to sterility, prolonged discharge of infectious lochia, carrier state or recovery. An identical spectrum may exist in the human. The pregnant animal can be infected parenterally, intranasally, conjunctivally and orally (dependent on the species) but the source of human infection is not known. Toaff et al[9] examined the husbands of 60 women with a history of repeated abortions. Three of the husbands had listeria in their semen with an associated lowered sperm count. Two of the corresponding wives had listeria in their vaginal secretions. The organisms remained in the semen after long periods of abstinence. Tetracycline therapy to the three couples resulted in higher sperm counts in two of the men and normal pregnancies in all three wives.

Other Types

1. Skin infections may be an associated finding in the infants with granulomatosis infantiseptica or an isolated finding usually in veterinarians.

2. Subacute bacterial endocarditis (mentioned under typhoid-pneumonic form).

3. Urethritis in the male.

4. Pneumonitis and "grippe."

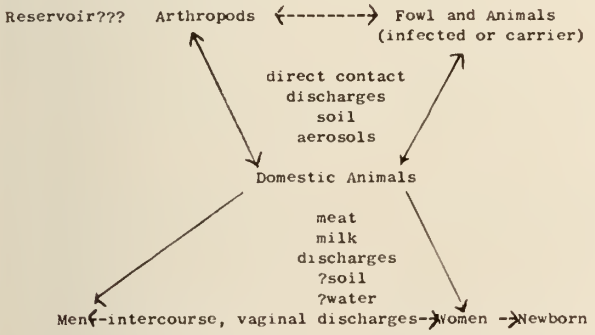
5. Isolated abscesses or as secondary involvement on a chronic illness.

6. Asymptomatic (as suggested by Osebold's report of a large percentage of veterinarians having elevated antilisterial antibody titers).

Discussion and Summary

Human listeriosis has been described in its major forms but the prevalence of each form remains to be more fully established. Measures to control this disease will have to be speculative until more information on the exact epidemiology is known. Listeria has been isolated in spring water, meat and in the tissues and discharges of infected animals. Ticks, flies, and mites have been found to harbor the organism, also, but probably play a minor role in the spread of the disease.

With the information at hand, one cannot help but have a conception of epidemiology similar to Seeliger's.[2]



With this scheme in mind, some suggested control measures would include:

1. Reduction of the reservoir
   (a) slaughter or treatment of infected animals or fowl
   (b) rodent and pest control
2. Control of food sources
   (a) high temperature pasteurization of milk
   (b) condemning infected meat after proper inspection
3. Isolation and treatment of the aborting or infected mother and infected infant
4. Increased interest and knowledge about Listeria and its diseases.

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(Further bibliography can be obtained on request to the authors.)

The Meaning of "Five-Year" Cure in Cancer of the Breast

Five hundred and twelve radical mastectomies performed from January 1, 1917 to January 1, 1945 have been studied with interest in long term survival. Two hundred and thirty-eight five-year cures were followed with 98 per cent completeness for 15 to 35 years. This analysis shows survival for five years after radical mastectomy must not be interpreted as cure; rather it represents a probability of living an additional indeterminate length of time. In this series, survival beyond the initial five-year period carried a probability of 78 per cent for five years; 57 per cent for 10 years, and 16 per cent for 20 years. Patients may still die of cancer of the breast after 35 postoperative years.

The presence of axillary metastases reduces the chance for five-year survival by 65 per cent. However, it does not materially influence survival beyond five years. Postoperative radiotherapy has not increased survival rates. The true salvage rates that can be credited to radical mastectomy (or those patients with axillary metastases) is small. In terms of 15-year survival, this constitutes about 9 per cent. However, since these results have not been achieved by any other means, the operation seems justified.—From a paper by Douglass G. Whitney, Roger F. Smith, and D. Emerick Szilagyi, presented before the Detroit Surgical Association, February 24, 1964.

Have *You* Written Your Congressman?

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Do It Now..Write *Today*

Supporters of socialized medicine are hard at work. Are you?

Blue Cross-Blue Shield Enrollment Open to Public, May 17-31

From May 17 through May 31, Blue Cross-Blue Shield coverage will be offered to *all* Michigan residents who cannot obtain it through group enrollment.

The effective date of coverage will be July 1, 1964.

The enrollment campaign is part of Blue Cross-Blue Shield's 25th Anniversary celebration and is designed for subscribers under 65 years of age as well as over 65.

There are no restrictions on eligibility. No physical examination is required.

Application blanks will be available through daily newspapers. Folders describing benefits, rates and enrollment information will be sent to all physicians.

Blow to Pocketbooks

(A recent editorial in the Detroit News, with the above heading, commented on President Lyndon B. Johnson's medicare proposal. Following are the closing paragraphs of the editorial.)

President Lyndon B. Johnson's proposal would result in another rise in social security bureaucracy. A tremendous increase in the number of federal employes would be needed to audit the hospital bills of the aged who would qualify under the program.

Mr. Johnson admitted that his proposals would not solve all the nation's health problems. He said they will not be solved by the federal government alone, nor even by governments at all levels, but "must be solved by society as a whole."

We agree. It's disappointing that he didn't propose more cooperation from the private economy.

From Our Public Relations Library

The following books are recommended to interested doctors as stimulating and informative. Send a note to MSMS Library, and the books will be sent by return mail for your perusal:

"Principles of Speech," by Alan H. Monroe (fourth brief edition)

"Television and Radio," by Giraud Chester and Garnet R. Garrison (second edition)

William A. Scott Medical Scholarship for Psychiatry

Calm, quiet, effective, dignified, beloved, hard-working, generous, thoughtful—these words and many more could be used to describe William A. Scott, M.D., of Kalamazoo.

The physicians of the State of Michigan were shocked by his untimely death and will miss him greatly.

At the suggestion of Mrs. Dorothy Dalton, the Civic Fund of Kalamazoo has established the William Scott Medical Scholarship for Psychiatry at the University of Michigan. It is a fitting and proper tribute to this fine man that this be done, for it makes it possible for his effectiveness in medicine and his influence upon it to continue at work.

Doctor Scott was a leader in the field of mental health, serving as a board member of the Kalamazoo Psychiatric Clinic, as a member of a special committee on consolidation of State Health agencies under the new Michigan constitution, and as a member of Governor Romney's Mental Health Advisory Committee. He had served as a Michigan State Medical Society Councilor since 1959 and as Chairman of the Publications Committee of the State Medical Society since 1961.

Michigan medicine salutes William A. Scott, M.D., and notes with pride the establishment of a scholarship in his honor.

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Medical Aspects Of Chronic Absence in Industry

By Wm. Jend, Jr., M.D.*

There are many causes of absence in industry, not all of which are medical as one might suspect. The two principal kinds of sickness absence, as we see it, are necessary absence and excessive absence. The former is beneficial to the individual and, usually beneficial to his employer and fellow workers. The latter is bad in the sense that it is probably not necessary—at least to the observer, if not the patient.

The agents responsible for most disabling illnesses are widely and randomly distributed throughout any environ-

*Medical Director, Michigan Bell Telephone Co.

ment. This causes us to wonder why it is then that only a few of the people become ill. Records which are well substantiated and gathered from a variety of sources and situations all indicate that a relatively small per cent of the people have most of the illness. Perhaps in part this arises from our limited concepts of what constitutes health and disease. The most careful physical examination by the most competent physician may not furnish a good prediction of the individual's future health. Strangely enough, those with psychoneurotic tendencies may, or may not, have a great deal of sickness absence.

What is sickness? One definition says that a person is sick when he is no longer able to perform his usual social roles. However, it is certainly possible to be sick in the medical sense and yet fulfill normal expectations in relations with others, particularly in terms of being on the job. It is also equally possible to be healthful in medical terms and yet be incapable of playing one's usual social roles.

What is so readily apparent is that it is not illness or disease itself but, rather, how the individual views it in the light of his past experience and conditioning and the experiences pressing upon him at a given moment. Frequent disability seems to be an individual characteristic. The control of absence is not primarily a medical problem but, rather, one of motivating people—with medical factors often, but not necessarily, superimposed on it. In much so-called sickness absence we are dealing with deep-seated personal and psychological situations with illness as the excuse.

All physicians, both in private practice and in industry, are involved in the social problem of determining the causes and the necessity for absence from work. Of all such absences attributed to illness and injury, about 90% are due to non-occupational causes. Also, only a small per cent of the total work force is employed in establishments which have in-plant medical programs. The family physician has great responsibility in certifying health conditions which justify absence and in returning the patient to work at the earliest opportunity. He is the chief validator of absence from work and the doctor who, in the vast majority of cases, determines the duration of disability. In all too many cases, we find that the doctor has allowed the patient to influence him on how long this absence should last. Burdensome as it may be to obtain adequate information, it is not enough, if better information is available, to take the patient's word for his degree of disability and the physical and emotional demands of the job.

While medicine came into industry through the compensation laws to provide prompt treatment of industrial accidents, this early concept has evolved until now when primary attention is devoted to human maintenance through preventive techniques. The physician in industry deals realistically in problems of job placement, over-all health maintenance and rehabilitation.

The physician in industry is, of course, in a position to evaluate and interpret medical reports on disabled employees. While the responsibility of the personal physician in contacting the physician in industry has been previously stressed, this is, of course, a two-way street. We often find through such contacts that the personal physician is not aware of the actual physical and emotional requirements of the job—nor of the company's willingness to temporarily, or even permanently, modify job requirements so that a valued employee may be rehabilitated. While it should not make a difference in his judgment, the personal physician is often surprised to find that an employee he has been certifying as disabled is continuing to receive full salary.

The tremendous expense of absence from work is, in the final analysis, borne by the consumer in the price he pays for the goods and services. The tremendous amount of absence that is unnecessary by any reasonable standard should concern all of us. Simple honesty and integrity also dictates that we do our best to distinguish between necessary and excessive, or unnecessary, absence. We realize that the bases of human health and behavior are complex and both medical and non-medical factors

are involved. However, because medical factors are so important in the absence problem in industry and because many doctors unwittingly help, if not encourage, their patients to be unnecessarily absent from work, no physician, be he the family doctor or the company medical director, can fail to assume his proper responsibility in this social problem.

Norman F. Miller, M.D.

By Charles S. Stevenson, M.D.

Not often enough in this life one is given the opportunity to pay tribute to a fellow man in such a way that many of his peers will view it. Such an opportunity has been afforded me in respect to the recent retirement of Norman F. Miller, long-time chairman of the Department of Obstetrics and Gynecology at The University of Michigan Medical School.

Dr. Miller's retirement brought to a close 32 years of stewardship of an excellence seldom known in this country. Dr. Miller's efforts were especially fruitful in the field of resident training—thanks in major measure to the forcefulness of his character, the imaginativeness of his brain, the originality of his research and the unswerving self-discipline in which he held himself.

He had the rare ability to bring out the best efforts of his trainees. When criticism was in order, criticism there was—constructive, paternal in nature. When any of his residents were sick or had sickness in their families, frequently the first one on hand to offer help was Dr. Miller.

There are many measures of greatness in a teacher. One of the yardsticks immediately available to us is the fact that seven of Dr. Miller's residents have become chairmen of obstetrics and gynecology departments throughout the country, a record that has no parallel in the past 30 or 40 years. A further significant tribute is the fact that one of Dr. Miller's former residents has succeeded him in the chair of the department.

I suspect that retirement will be just a word for Dr. Miller. His colleagues will be seeking his opinion and advice. His patients will undoubtedly continue to seek his magnificent care. His friends will turn to him frequently when they feel the need of good fellowship. The departments of obstetrics and gynecology in this country and abroad will continue to invite him to lecture as a visiting professor—an area in which this man is at his very best.

Dr. Norman F. Miller, raised in Michigan with love and humor by Swedish-born parents, a graduate of The University of Michigan (both Bachelor and Doctor of Medicine degrees), has earned and been accorded national and international recognition in his field. It is my purpose here to indicate in frail words the deep affection and great respect that all of us hold for him.

Measuring Up

Physicians, as individuals and through their organizations, continually take stock of themselves, their knowledge, their competence, and their effectiveness. It is interesting to apply a yardstick to the Michigan State Medical Society as a professional association.

Executives at the Institute for Organization Management, held at Michigan State University in 1963, received the following profile of a successful association:

An existence of at least five years;

Objectives and functions that are acceptable to the industry or profession it serves and meeting the needs of the membership as developments occur;

Recognized and respected as a leadership or direction-giving force within the industry or profession served;

An organization in tune with the times and constantly in the process of re-examining itself in preparation for the future;

Responsible for developing within the membership a positive attitude; and

Maintaining the confidence of recognized leaders in the community.

The Michigan State Medical Society clearly meets each characteristic described for a successful association and its continued growth and vigor are a result of thus measuring up.

MSMS Centennial Series

Governor Murphy Signs Basic Science Bill in 1937

By William J. Stapleton, Jr., M.D.
Detroit, Michigan
MSMS Historian

One of the most important events of the year, medically speaking, was the signing on May 27, 1937, by Governor Frank Murphy of the Basic Science Bill.

The Basic Science Bill was designed to regulate the practice of healing in the State of Michigan and to provide for examinations in basic sciences as a prerequisite to practicing the art of healing in this state.

A six-man board is to be appointed by the governor. This board must give at least two tests a year. In order to qualify, the applicant must pass each test with a score of at least 75 per cent. The basic sciences are taken to be anatomy, physiology, pathology, bacteriology, hygiene and public health, and chemistry.

* * *

Among the important activities of the MSMS and the County Societies during 1937 were:

I. **Legislation:** (1) Basic Science Bill brochure "Michigan Needs a Basic Science Law", (2) Occupational Disease Bill, (3) Workman's Compensation Law, (4) Welfare and Relief with ten proposed bills including the Afflicted and Crippled Child Law, (5) Social Security—including maternal and child welfare and syphilis control, (6) Group Hospitalization, and (7) Cult Proposals.

II. **Economics:** (1) The State Society's five points for the Welfare Commissions Bill, (2) Post-payment plans for the borderline group, (3) Socialized medicine brochure: "Who Wants Socialized Medicine?"

III. **Medical Speakers** before lay groups and organizations: (cooperation from Joint Committee on Health Education).

IV. **Speakers** on scientific subjects for scientific programs of county societies.

V. **Radio Programs** over 18 stations throughout the state.

VI. **Exhibits** at the Anual Meeting of the MSMS.

VII. **MSMS Bureau of Information** contacting 425 newspapers.



Henry E. Perry, M.D.
MSMS President
1936-37

IX. **Medical Columns** in city and county newspapers.

X. **The Filter System.**

XI. **County Health Units**—Educational and Administrative.

XII. **Non-practice Protection.**

XIII. **Ethics Committee of the MSMS.**

XIV. **Development of Woman's Auxiliary Units.**

XV. **Membership Campaigns** for eligible nonmembers.

The continued interest in Postgraduate work told of University of Michigan courses held at the University Hospital, Ann Arbor, from April 5, 1937 to August 20, 1937. The courses dealt with Electrocardiograph Diagnosis, Diseases of Metabolism, Ophthalmology and Otolaryngology, Diseases of the Blood and Blood-Forming Organs, Surgery, Medical Roentgenology, and Laboratory Technique and Clinical Microscopy. A course in Pediatrics was given at Henry

(Continued on Page 300)



The Author
WILLIAM J.
STAPLETON, JR., M.D.
MSMS Historian

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It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine SEARLE

(Continued from Page 298)

Ford and Children's Hospitals. At Receiving Hospital, Detroit, the courses ran from April 26 through May 7, covering Proctology, Diseases of the Genito-Urinary Tract, Gynecology, Obstetrics, and Gynecological Pathology.

For those interested, there is an article on Malpractice in the March issue of THE JOURNAL.

In early 1937, the Woman's Field Army of the American Society for the Control of Cancer was founded to educate lay people as to the cause and prevention of cancer. Michigan Auxiliary members quickly offered their services. At their suggestion, Governor Murphy proclaimed March 21-27 "Fight Cancer Week Throughout the State."

* * *

The mid-winter meeting of The Council approved a Venereal Disease Control Program with preservation of doctor-patient relationship. Points covering medical phases of relief and welfare were agreed upon for inclusion in proposed recodification laws. A committee is to be formed to represent the MSMS, the Michigan Hospital Association and the Michigan Association of Roentgenologists in Crippled-Afflicted Child Work.

In May, 1937, the first medical supplement in a Michigan newspaper appeared in *The Detroit Free Press*. The announcement read: "It (the medical supplement) will be published by the Wayne County Medical Society who will furnish information about the County Society and stories about medical projects and medical men."

The Joint Committee, comprised of representatives from various institutions concerned with health, worked in four fields—State Welfare Law, Medical Care in Michigan Prisons, Occupational Disease Law, and Formation of Full-Term Health Units. It is amazing to read what the MSMS and its committees and members do during a year.

* * *

The Michigan legislature, in addition to passing the Basic Science Law, also approved bills which provided for an appropriation of $50,000 for syphilis control, an Ante-Nuptial Examination Law, a law to allow the teaching of social hygiene in public schools by qualified physicians, a law providing compensation for occupational diseases, the liberalization of old-age assistance, the hospital building program, recodification of Afflicted and Crippled Child laws, a law regulating strictly the growth of marijuana and other narcotics, divorcing the State Hospital Commission from the State Welfare Department and revising the laws under which it operates, laws to protect the blind in Michigan, a law governing the unethical practice and advertising of optometry, and a law to provide for treatment and compensation of typhoid carriers.

The Council's Executive Committee ordered that THE JOURNAL MSMS be copyrighted.

Henry E. Perry, M.D., of Newberry, served as president during 1936-37.

People Are Individuals First!

"Those who oppose the drive for security, particularly government Social Security programs and public welfare benefits, do so not because they want to foster insecurity or because they are indifferent to human suffering.

"They are not against security. But they do believe that 'people' are individuals first. They should be treated as human beings, as individuals. Youngsters should be taught and expected to exercise foresight, self-restraint, self-discipline. People should not be thought of en masse. The individual grows and gains self-realization, self-satisfaction and self-respect when he does things for himself, on his own. The citizen who acquires through his own earnings a bit of property in the community gains respect from the individuals in the community and he gains self-respect. He feels that he is 'of the community' and 'supports the community.' He then has a sense of belonging.

"While much is to be said for certain security programs, the proponents of 'cradle to the grave' compulsory security programs have generally failed to understand the deep underlying philosophy of their opponents."—Excerpts from "Individual and Group Security," Chamber of Commerce of United States.

Wayne Medical Alumni Event Set for May 20

Wayne State University President Clarence B. Hilberry and Chrysler President Lynn A. Townsend will be honored by medical alumni at the 96th Alumni Reunion and Clinical Program of Wayne State University's School of Medicine, Wednesday, May 20, at the Sheraton-Cadillac Hotel.

The recipients of the Alumni Awards are being recognized for their contributions to education in areas related to medicine.

The scientific program, featuring eight papers, begins at 9:30 a.m. A reception at 5:45 p.m. will precede the reunion dinner dance.

President of the alumni group is Jacob F. Wenzel, M.D. President-Elect is Hugh W. Henderson, M.D.

Program participants from Wayne's School of Medicine include: Peter A. Martin, M.D., associate clinical professor of psychiatry, "The Problem of Identity"; Charles F. Whitten, M.D., associate professor of pediatrics, "Acute Iron Poisoning in Children"; and Benjamin M. Lewis, M.D., professor of medicine, "The Hazards of Country Living."

Among the outstanding speakers is Frederick F. Yonkman, M.D., vice president in charge of research with Ciba at Summit, N. J. A native of Holland, Michigan, and a graduate of Hope College, he later obtained his M.D. degree from Boston University and was head of the department of pharmacology at Wayne during 1939-44, when he joined Ciba. Other speakers are: Garnet W. Ault, M.D., clinical professor of surgery, Georgetown University, Washington, D. C., "The Surgical Management of Ulcerative Colitis"; Frederick F. Yonkman, M.D., vice president in charge of research, Ciba, Summit, New Jersey, "What's in a Figure?"; Benjamin W. Drompp, M.D., professor and head, division of orthopedic surgery, University of Arkansas, Little Rock, Arkansas, "Salvage Procedures for the Failure of Primary Hip Surgery"; T. Manford McGee, M.D., chief, division of otology, Henry Ford Hospital, Detroit, "Current Trends in Otologic Surgery"; and Henry R. Thompson, M.D., consultant surgeon, St. Mark's Hospital, London, England, "The Barber Surgeons of London."



F. F. Yonkman, M.D.



Michigan Health Council Reports Recent Placements

Recent placements by the M.D. Placement Service have included the following: Marguerite R. Shearer, M.D. (University of Michigan Health Service, Ann Arbor); Armand M. LaSorsa, M.D. (Manistique Clinic, Manistique); John R. Tarr, M.D. (Camden); David W. Shave, M.D. (Niles); Alfred W. Foerster, M.D. (Owosso Medical Group); Leo F. Quinn, M.D. (Niles); David A. Johnson, M.D. (Bay City); Lloyd S. Rotz, M.D. (Grand Haven); Dennis W. Harvey,

M.D. (Grand Haven); Jerzy Walczyk, M.D. (Mt. Pleasant State Home and Training School); Zofia Walczyk, M.D. (Mt. Pleasant State Home and Training School); Robert C. Rood, M.D. (Detroit); Basil Hadjimihaloglou, M.D. (Detroit); Jose M. A. Moreno, M.D. (Howell); John F. Pillote, M.D. (Medical Building, Marquette, Michigan); Philip R. Glotfelty, M.D. (Oaklawn Hospital, Marshall, Michigan); William K. Stewart, M.D. (Union City).

Michigan Heart Association Elects New Officers

James B. Blodgett, M.D., Detroit, is the new president-elect of the Michigan Heart Association, chosen recently at the annual meeting in Detroit.

The president now is Park W. Willis, M.D., Ann Arbor. The retiring president was Sidney Chapin, M.D., Dearborn.

Three physicians were elected to the board—Carl B. Beeman, M.D., and Larry H. Birch, M.D., both of Grand Rapids, and Herbert A. Sloan, Jr., M.D., Ann Arbor.

Spotlight on Physicians During MAP Congress

Four Michigan doctors of medicine figured prominently in the successful 5th Annual Congress of the Professions, held in Lansing.

Luther R. Leader, M.D., Bloomfield Hills, was re-elected to the MAP Board of Directors;

Frank D. Richards, M.D., Lansing, was chairman of the MAP Congress planning committee;

John W. Rice, M.D., Jackson, received an award for service on the MAP Board, and

G. D. Cummings, M.D., Lansing, spoke at a general assembly about "Money as It Effects Research."

Several other doctors came to Michigan to speak at the Congress sessions. Leonard W. Larson, M.D., AMA Past-President, discussed "Money as It Affects Professional Education," and Carl R. Ackerman, M.D., New York, talked about "Money as It Effects Professional Practice."

Sponsored by the Michigan Association of the Professions, the Congress drew over 600 persons. Many doctors, headed by MSMS President Orlen J. Johnson, M.D., participated in the committee hearings, general assemblies and banquet programs.

Another highlight of special interest to MSMS mem-



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bers was the presentation of an "Outstanding Service Award of the Year" to Hugh W. Brenneman. The citation read, "Of all men, he has rendered the greatest service to the professions in Michigan during 1963."

28 Medical Assistants "Certified"

The national certification program for the American Association of Medical Assistants is underway. Twenty-four persons from eight states have received the first certificates as "Certified Medical Assistants." These individuals qualified out of a field of 108. Information about this new program may be obtained from the AMA headquarters.

Cancer Coordinating Committee Re-elects Officers for 1964

Three officers of the Michigan Cancer Coordinating Committee were re-elected at the recent annual meeting—B. E. Luck, D.D.S., Lansing, as chairman, Henry J. VandenBerg, Jr., M.D., Detroit, as first vice president, and John W. Cowan, M.D., Lansing, as second vice president. The secretary is Warren F. Tryloff, MSMS associate executive director.

Member organizations of the Committee are the American Cancer Society, Southeastern Michigan Division; American Cancer Society, Michigan Division; Michigan Department of Health; Michigan Cancer Foundation; Michigan Health Officers Association; Michigan State Dental Association, and the Michigan State Medical Society.

UP Medical Society Meeting Set for Houghton in June

Early plans are well under way for the 71st Annual Meeting of the Upper Peninsula Medical Society at Houghton, June 12-13, according to Andrew M. Roche, M.D., President, of Calumet.

The Houghton-Baraga-Keweenaw County Medical Society will serve as the host.

Secretary of the U.P. Society is John B. Albright, M.D., Laurium.

Medical-Dental Ski Group Re-elects, Sets 1965 Dates

The 50 physicians and dentists who participated in the recent meeting of the Canadian-American Medical

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and Dental Ski Association at Harbor Springs re-elected all Association officers.

John Hall, M.D., Sault Ste. Marie, Ontario, was returned as president; Donald Conley, M.D., Marquette, president-elect; George Mullin, M.D., Sault Ste. Marie, vice president, and T. J. Trapasso, M.D., Sault Ste. Marie, secretary-treasurer.

The next meeting again will be held at Boyne Highlands, Harbor Springs, February 22-26, 1965.

Speakers at the 1964 meeting included Robert D. Larsen, M.D., William A. Lange, M.D., and Dean A. Robb, LL.B., all of Detroit, and Clare H. Grosenbaugh, M.D., Grand Rapids.

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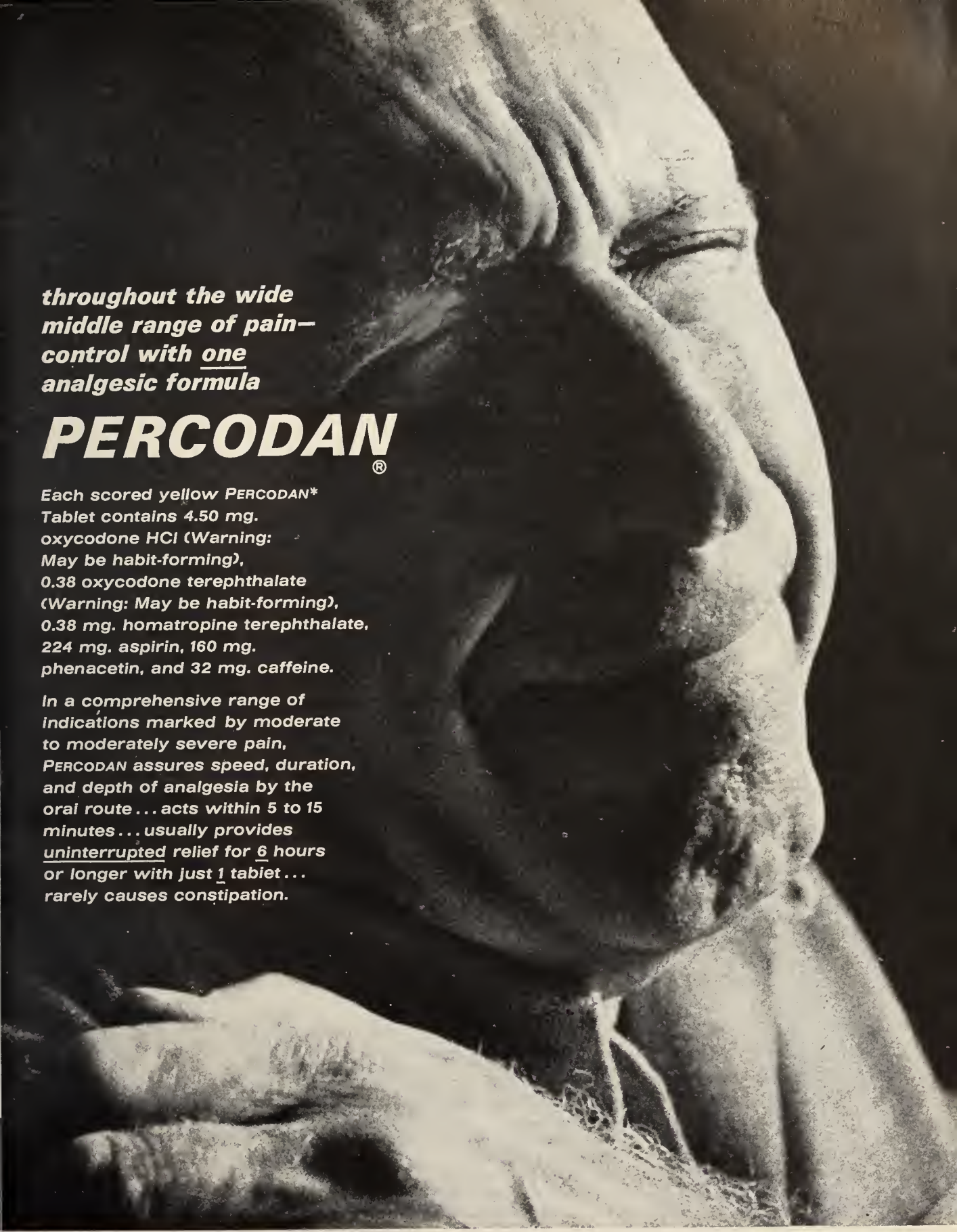
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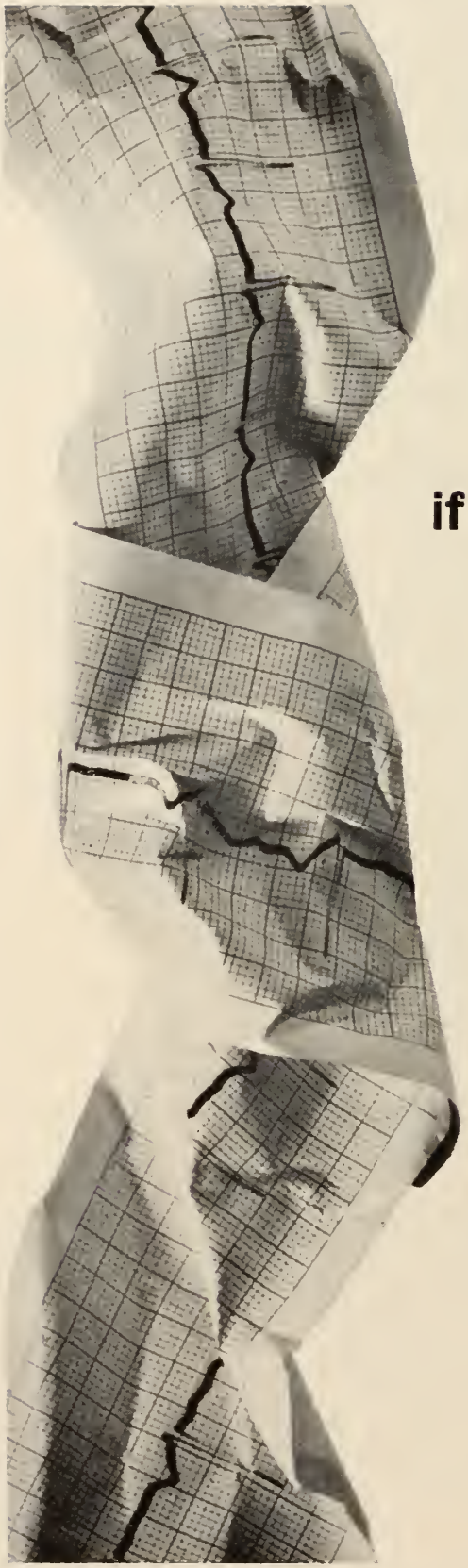
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Say you saw it in the Journal of the Michigan State Medical Society

Brief and to the Point

Recently retired from service with the Oakland County Health Department was **JOHN S. LAMBIE, M.D.**, 81 years young. He joined the Oakland department in 1949 after 22 years as plant physician for Fisher Body in Pontiac . . . **RALPH GREEN, M.D.**, Rochester, presided as president at the annual meeting of the Central Neuropsychiatric Hospital Association in Chicago and gave a paper on "An Approach to Interdepartmental Integration in the Hospital" . . . During 1963, the Michigan Epilepsy Center and Association provided services to 2,297 persons, according to a report from **BENJAMIN JEFFRIES, M.D.**, president of the Association.

An intensive care addition to the War Memorial Hospital at Sault Ste. Marie will honor the late **A. H. GOLDBERG, M.D.**, former chief of staff there . . . Seven doctors from Wayne and Oakland counties form the board of directors for Woodside Medical, a subacute care facility that will open in Pontiac about May 1 . . . After eight years as chairman of the Michigan Kidney Disease Foundation, **JOSEPH A. JOHNSTON, M.D.**, Detroit, has been honored by election as "honorary chairman" of the advisory board. The newly-elected chairman is **REUBEN MEYER, M.D.**, Detroit.

RICHARD J. BING, M.D., Detroit, and **MAURICE H. SEEVERS, M.D.**, Ann Arbor, are members of the new AMA Committee for Research on Tobacco and Health. Doctor Seevers is the chairman of the Committee, which recently received $10,000,000 from six tobacco companies for basic research . . . **C. G. DARLING, JR., M.D.**, has entered private practice after retiring from GMC Truck and Coach Division at Pontiac where he was medical director for 35 years.

A recent feature article in the Jackson *Citizen-Patriot* about **ALGER A. PALMER, M.D.**, Chelsea, described him as a "Civil War buff"—his chief hobby . . . A National Education Association travel group to Fiji, Tahiti, New Zealand, Australia, etc., included **W. D. TOWSLEY, M.D.**, Midland . . . Panelists for a program about industrial accidents before the Benton Harbor-St. Joseph Safety Council were **DAVID W. HILLS, M.D., JOHN KENFIELD, M.D.**, and **EDWARD C. HAUPT, M.D.**, all of Berrien County . . . **EDWARD M. VARDON, M.D.**, Highland Park, according to a recent *Detroit News* feature, "has the world's largest and most complete library on English bulldogs."

CHARLES SELLERS, M.D., Detroit, discussed Chinese art recently at a meeting of the Detroit Scarab Club . . . Moving to California recently was **VICTOR A. LOOKANOFF, M.D.**, Highland Park. He left a position as chief radiologist at Highland Park General Hospital to become chief radiologist at the Veterans Administration Hospital in Livermore, California . . . A public forum in Muskegon about arthritic quackery recently featured talks by **JAMES J. LIGHTBODY, M.D., JOSEPH N. SCHAEFFER, M.D.**, both of Detroit, and **GEORGE THOMPSON, M.D.**, Ann Arbor.



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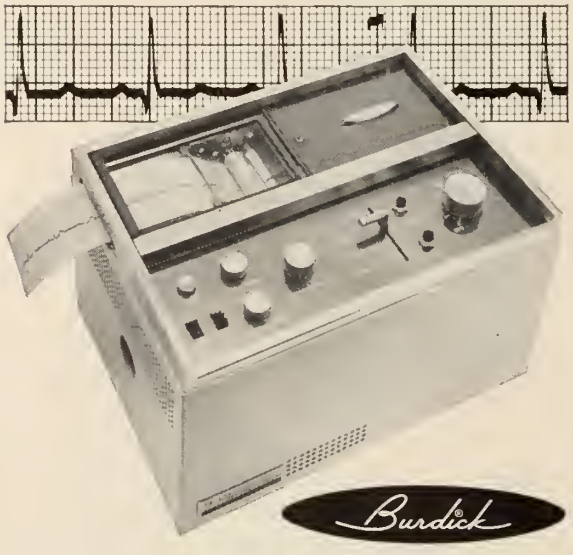
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Doctor Leach Is Leader In National Foundation

A Michigan doctor is playing a prominent role in the new work of the Richard Allen Foundation to call the attention of Negro young people to the relations of cigaret smoking to health. J. L. Leach, M.D., of Flint, is executive secretary of the Richard Allen Foundation, which presented a panel program about cigarets-and-health at the recent meeting of the African Methodist Church's Bishop's Council in New Orleans. The Richard Allen Foundation, organized in Michigan, "is endeavoring to perform vital services for its church and members especially in the field of young people and in the field of better race relationships," according to Doctor Leach. The A.M.E. includes 32,000 member churches and the foundation honors Richard Allen, founder of the movement in 1787.



J. L. Leach, M.D.

Michigan Authors

R J. Ging, M.D., Elizabeth Jones, M.D., and **Melvin Manis, Ph.D.,** Ann Arbor, "Electroencephalograms and Multiple Physical Symptoms" *Journal of the American Medical Association,* February 22, 1964.

Leo S. Figiel, M.D., and **Steven J. Figiel, M.D.,** Detroit, "Acute Organo-Axial Gastric Volvulus", American Journal of Roentgenology, Radium Therapy and Nuclear Medicine, October 1963.

Leo S. Figiel, M.D., Steven J. Figiel, M.D., and **Alan Hennessey,** "Carcinoma of the Colon—Incidence of Error in the Roentgen Diagnosis," *American Journal of Gastroenterology,* November, 1963.

Leo S. Figiel, M.D., and **Steven J. Figiel, M.D.,** "Colocolic Intussusception", *The American Journal of Digestive Diseases,* December, 1963.

Steven J. Figiel, M.D., and **Leo S. Figiel, M.D.,** "Intraluminal Duodenal Diverticulum", *The American Journal of Digestive Diseases,* May, 1963.

IN MEMORIAM

LELAND F. HYSLOP, M.D., 66, Mount Pleasant physician since 1942, died February 8, 1964.

A graduate of Vanderbilt and Northwestern Universities, Doctor Hyslop was a member of the American College of Surgeons. He was the first chief of staff at Mt. Pleasant's Central Michigan Community Hospital.

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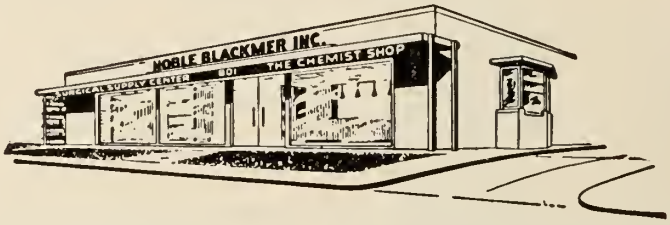
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Books received by THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY *are acknowledged in this column. Selections will be made for more extensive review in the interest of readers as space permits.*

"Harper of Detroit" Is Rich with Anecdotes

The dramatic story of the growth of a famous medical institution over a hundred years of progress is the subject of a book, *Harper of Detroit*, recently published by the Wayne State University Press in Detroit.

The book tells of buildings and equipment but also tells the human story of the doctors, nurses and interested citizens who pioneered the scientific and medical advances.

This history starts with Harper Hospital's beginning in 1864 as a military hospital for the casualties of the Civil War battlefields, and details Harper's achievements to the present day.

The history is rich with anecdotes of the early philanthropists who donated the land for the hospital. Chief among them was Walter Harper, an immigrant Irishman, who gave over eight hundred acres of land to the city so they could build a hospital for the "care and relief of aged or sick persons."

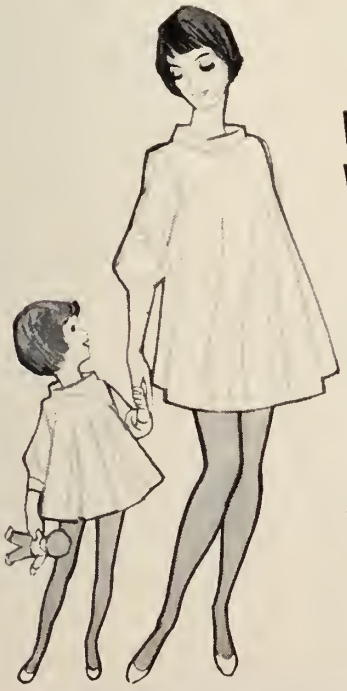
Another key figure was Nancy Martin, one-time servant girl, who became a dynamic vegetable dealer on Woodward Avenue. It was she who donated the five acres of land between Woodward and John R. where Harper Hospital now stands, near the core of the new Detroit Medical Center.

Familiar names of the people who made Detroit history are found in this history. Biographies, profiles, a bibliography, a chronology and many rare historic photographs are also included.

The book does not omit details of the growing pains of hospitals. In 1888, Grace Hospital was built two blocks from Harper's and the book says the competition between each hospital's ambulances for pick-up of accident victims was so keen that "Detroit was frequently treated to a scene resembling the chariot race in Ben Hur." Eventually order was restored with the contracting of private ambulance service.

The four times that Harper Hospital met the needs of a nation at war are recounted. There is the story of the doctors and the nurses from Harper who went to Naples in the second world war to work in a hospital there and survived the bombing of the hospital by Nazi planes.

The book concludes with the story of the postwar building boom and the resultant movement toward urban renewal which paved the way toward the Detroit Medical Center and a new role for Harper Hospital.



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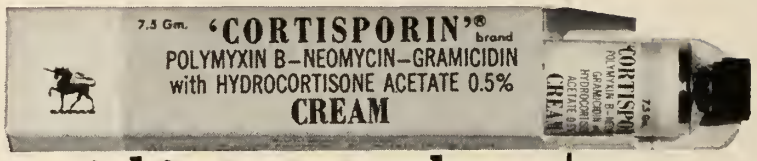
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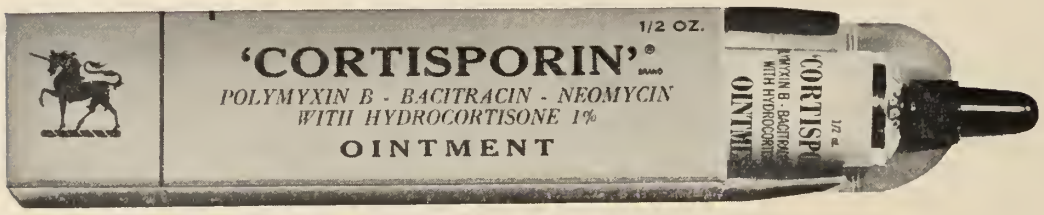
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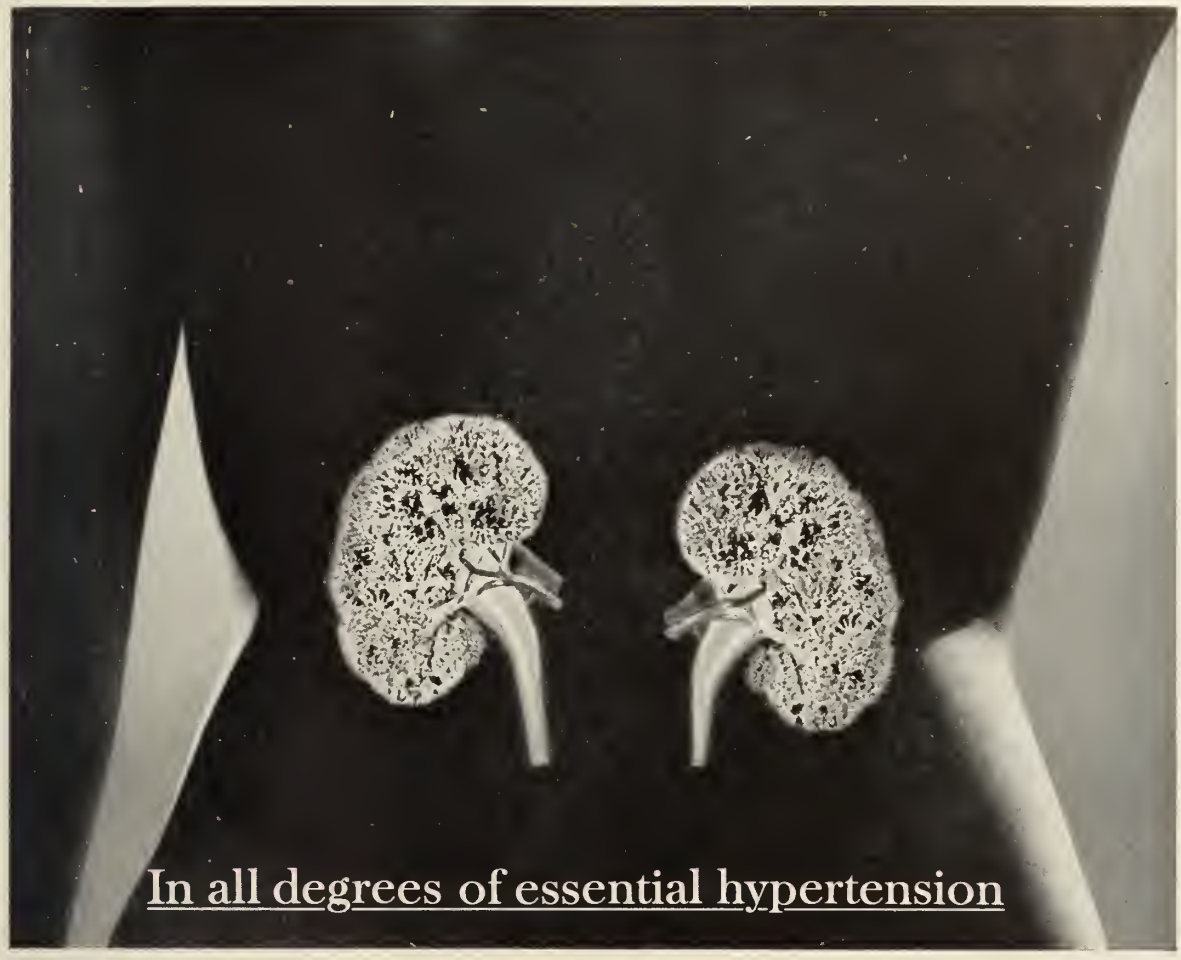
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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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Delegates

	Term Expires
C. I. Owen, M.D., Detroit	1964
G. W. Slagle, M.D., Battle Creek	1964
D. N. Sweeny, Jr., M.D., Detroit	1964
J. R. Heidenreich, M.D., Daggett	1965
W. A. Hyland, M.D., *Chairman*, Grand Rapids	1965
O. J. Johnson, M.D., Lansing	1965
L. R. Leader, M.D., Birmingham	1965

Alternates

	Term Expires
R. E. Rice, M.D., Greenville	1964
A. Hazen Price, M.D., Detroit	1964
E. E. Martmer, M.D., Grosse Pte	1964
Sidney Adler, M.D., Detroit	1965
G. B. Saltonstall, M.D., Charlevoix	1965
B. M. Harris, M.D., Ypsilanti	1965
L. A. Drolett, M.D., Lansing	1965



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Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

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President's Page

MDPAC DESERVES YOUR SUPPORT TODAY



Arlen J. Johnson M.D.

President
Michigan State Medical Society

The medical profession long supported Michigan Medical Minute Men. Now a new broadened organization has been formed—MDPAC—Michigan Doctors Political Action Committee. The national organization is AMPAC, American Medical Political Action Committee. Both are separate and independent of all other medical organizations.

The major purpose of MDPAC and AMPAC is EDUCATION, by providing members with publications, and with instructions in voter registration.

The second purpose is SUPPORT of candidates—regardless of party, whose record and political stature are in accordance with the medical profession's philosophy of good government. In this phase AMPAC in the 1962 elections successfully evaluated and supported candidates in 70% of its efforts. A good record. It showed that its activity is a potent force in candidate election. It is so recognized.

MDPAC functions in all elections—local, state and national. AMPAC's scope is primarily national elections in all states.

Most physicians have some degree of interest in the effect of government on their practice and lives. Some have propensity for political activity. When a physician is not active in campaigns he can be effective through financial support of the organizations which are performing in his interest.

The success of a candidate is determined long before the election. Energy and assistance now are much more valuable than in October.

No one can deny that we are on a toboggan toward socialism in all phases of our lives. Are we going to ride it or brake it? No matter how legislative measures turn out in the next few weeks and months we have a continuing interest and a job to do. It can only be done by political activity or support. We are spinning our wheels if we look only at the issues and not at the men behind them.

NOW is the time to support MDPAC.

19 MSMS Clinic Days Offered in May, June

An ambitious calendar of Postgraduate Education Clinic Days awaits members of the Michigan State Medical Society this spring.

"The Clinic Days across the state provide excellent opportunities for Michigan physicians to constantly learn more about diagnosis and treatment," points out John M. Sheldon, M.D., Ann Arbor, Chairman of the MSMS Postgraduate Medical Education Committee.

The MSMS Committee has arranged for a series of 19 Clinic Day programs using faculty teams from the University of Michigan and Wayne State University schools of medicine as the "traveling faculty." Also cooperating with MSMS in the project is the Michigan Department of Health.

The MSMS Committee members suggest the general topics and then a local committee helps to select the topics and speakers. Usually, the MSMS Councilor serves as chairman for the programs in his area—and in some areas the members of the MSMS postgraduate education committee preside. The educational events are offered both in the spring and the fall.

These programs are another service of MSMS to the members—no registration fee is charged.

Battle Creek, May 5

6:30—Dinner, Hart Hotel
7:30—Program, Samuel J. Behrman, M.D. University of Michigan

Midland, May 14

2:00—Clinical Conference, A. C. Curtis, M.D.; Marion S. DeWeese, M.D.; A. James French, M.D.; Reed M. Nesbit, M.D.; Wm. D. Robinson, M.D.; John M. Sheldon, M.D.; Harry A. Towsley, M.D., and Walter P. Work, M.D., all of U-M
6:30—Dinner and Program, William N. Hubbard, Jr., M.D., Dean, University of Michigan

Petoskey, May 14

4:30—Clinic, Little Traverse Hall
6:30—Dinner, Perry-Davis Hotel
7:30—Program, Robert J. Bolt, M.D., and Robert O. Kraft, M.D., University of Michigan

Muskegon, May 15

6:00—Dinner, Muskegon Country Club
7:30—Program, Bernard A. Bercu, M.D., Univ. Michigan

Lansing, May 19

6:30—Dinner, Jack Tar Hotel
7:30—Program, Bernard A. Bercu, M.D., Univ. Michigan

Jackson, May 19

6:30—Dinner, Hayes Hotel
7:30—Program, Daniel W. Myers, M.D., Wayne State

Niles, May 19

6:30—Social Hour, Pickwick Club
7:30—Dinner
8:30—Program, A. Martin Lerner, M.D., Wayne State

Grayling, May 20

6:30—Dinner, Shoppenagons Inn
7:30—Program, William S. Wilson, M.D., University of Michigan

Cadillac, May 21

4:30—Clinic, Mercy Hospital
6:30—Dinner, The Armory
7:30—Program, William S. Wilson, M.D., University of Michigan

Alpena, May 28

5:00—Clinic, Alpena Hospital
6:00—Program, Ernest M. Berkas, M.D., and Richard S. McCaughey, M.D., both of Wayne State University
7:00—Dinner, The Grove

Port Huron, June 9

6:30—Dinner, Black River Country Club
7:30—Program, Andrew J. Zweifler, M.D., and William W. Coon, M.D., both of University of Michigan

Bay City, June 10

6:30—Dinner, Wenonah Hotel
7:30—Program, Walter P. Work, M.D., Univ. Michigan

UPPER PENINSULA

Sault Ste. Marie, May 18

5:00—Clinic, War Memorial Hospital
6:00—Social Hour, Ojibway Hotel
7:00—Dinner
8:00—Program, Joseph W. Hess, M.D., and Andrew A. Freier, M.D., both of Wayne State University

Escanaba, May 19

6:30—Dinner, The Terrace
7:30—Program, Joseph W. Hess, M.D., and Andrew A. Freier, M.D., both of Wayne State University

Ironwood, May 19

3:30—Clinic, Grand View Hospital
6:30—Dinner, Gogebic Country Club
7:30—Program, W. P. Work, M.D., and James L. Wilson, M.D., both of the University of Michigan

Menominee, May 20

3:30—Clinic, St. Joseph Lloyd Hospital
5:30—Program, Joseph W. Hess, M.D., and Andrew A. Freier, M.D., both of Wayne State University
7:00—Dinner

Houghton, May 20

3:30—Clinic, St. Joseph Hospital, Hancock
6:30—Dinner, Douglass House, Houghton
7:30—Program, Walter P. Work, M.D., and James L. Wilson, M.D., both of University of Michigan

Iron Mountain, May 21

3:30—Clinic, Veterans Hospital
6:30—Dinner, Chippewa Club
7:30—Program, J. W. Hess, M.D., and A.A. Freier, M.D., both of Wayne State University

Marquette, May 21

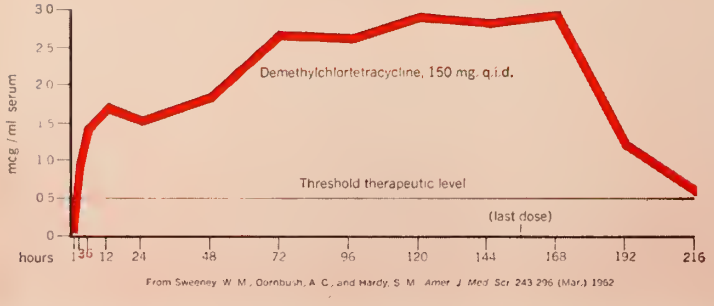
6:30—Dinner, Northland Hotel
7:30—Program, Walter P. Work, M.D., and James L. Wilson, M.D., both of University of Michigan

(Turn to Page 326)

only 150 mg. versus 250 mg.

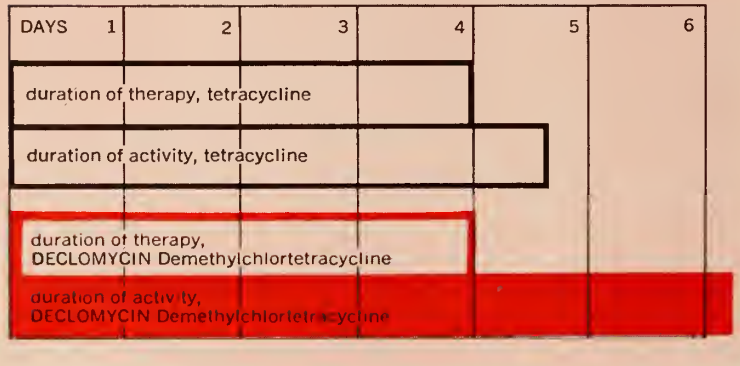


higher activity levels than other tetracyclines



From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962

1-2 days' "extra" activity





gives you an "extra dimension" of antibiotic control

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.



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DEMETHYLCHLORTETRACYCLINE HCl

Side Effects typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. **Capsules,** 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d.

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Early Plans for Michigan Health Fair in 1966 Well Under Way; Contacts Started with Schools

Plans are fast taking shape for the "Michigan Health Fair" to be presented in the spring of 1966 in Detroit by the Michigan State Medical Society.

The Fair, designed for both school children and adults, will be the highlight of the MSMS Centennial observance.

Orlen J. Johnson, M.D., Bay City, MSMS President, reports that more than 300 exhibits will be installed in Cobo Hall for the Fair, which will open April 30 and conclude on May 8, 1966. Doctor Johnson estimates that the project will draw more than 300,000 persons. Children will attend during the day, thus reserving the evenings for adults and families.

MSMS will invite other health organizations and agencies to participate. The many exhibits will develop the Fair theme of "One Hundred Years of Progress in Health."

Don W. McLean, M.D., Detroit, General Fair Chairman, reports students will make special trips to see the Fair. "We wish to provide an opportunity for the students to obtain a retrospective view of progress in health during the past 100 years and also help them consider the many health careers."

The Health Fair Committee will help to prepare teaching materials in cooperation with the Detroit public school system so science teachers can take full advantage of the Fair to enrich the school work.

MSMS Mental Health Congress, June 26

Every member of MSMS is invited to attend a MSMS-sponsored "Congress on Mental Illness and Health" at the Statler-Hilton Hotel, Detroit, Friday, June 26, 9:30 a.m. to 5:00 p.m.

Edward H. Rodda, M.D., Bay City, Program Chairman, explains that "The Congress will seek to examine Michigan's mental health needs and bring forth definite recommendations on how these needs can be fulfilled under the community mental health programming."

Benjamin Jeffries, M.D., Chairman of the MSMS Mental Health Committee, reports, "In general, the Congress will be conducted with medical leadership for all on the state level who are interested in Mental Health. The event will involve among others, educators, jurists, sociologists, psychologists, lay persons and lay organizations—as well as the medical profession."

Featured speakers will include Marvin E. Perkins, M.D., Commissioner of the Community Mental Health Services of New York City; Harold M. Visotsky, M.D., Commissioner of Mental Health for Illinois; and James G. Miller, M.D., chief of the Psychiatric Research Institute at the University of Michigan.

(More MSMS News, Page 344)

Quoted by SAMA

Portions of a letter carried in the MSMS JOURNAL November 1963, from E. W. Caster, M.D., Oak Park, recalling his 50 years of practice, were printed in the March issue of "The New Physician," official publication of the Student American Medical Association. The letter commented on the differences between the practice of medicine "now and then."

Michigan Medical Meetings

May 20—Wayne State University Clinical Program and Alumni Reunion Banquet, Sheraton-Cadillac Hotel, Detroit.

May 21-22—Seventh Annual Children's Hospital Clinic Days, Wayne County Medical Society, Detroit.

May 23-24—Michigan Kidney Disease Foundation, Henry Ford Hospital, Detroit.

June 12-13—Upper Peninsula Medical Society, Annual Meeting, Houghton.

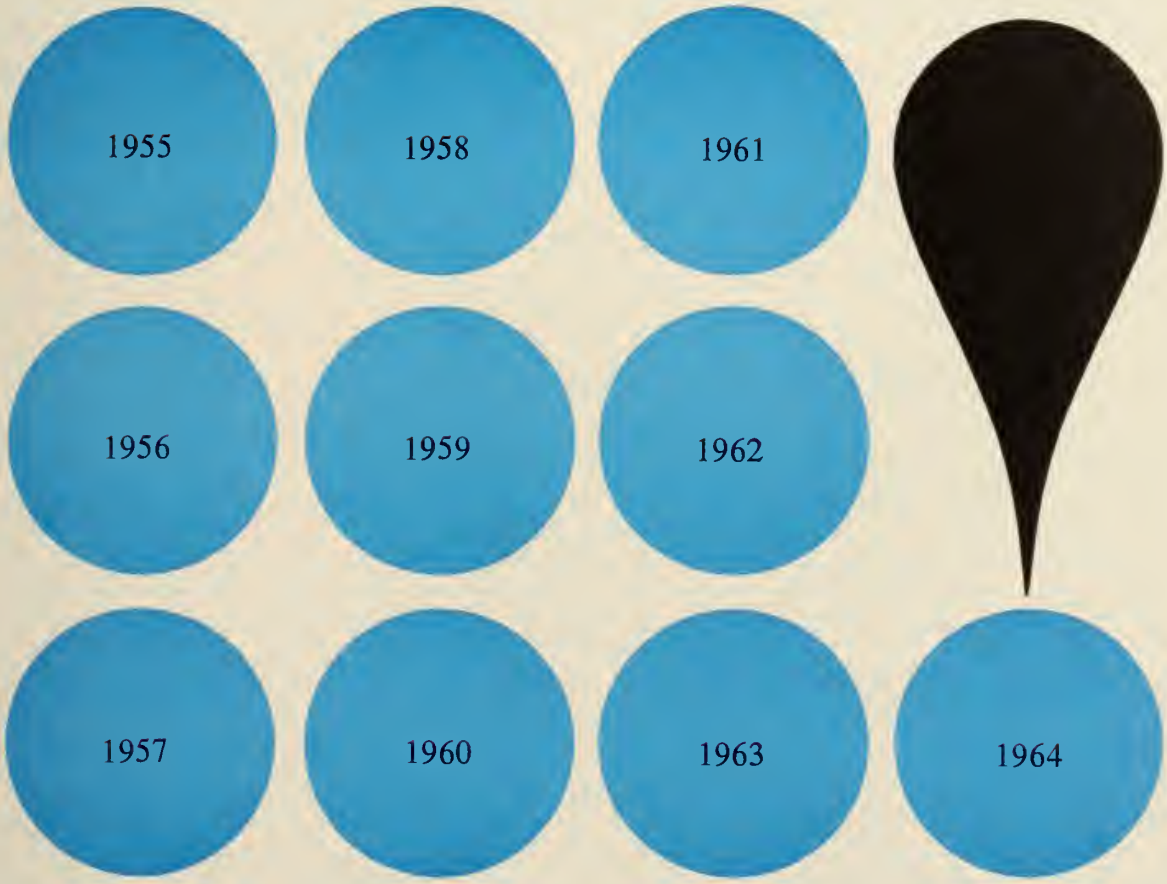
June 14-16—Michigan Hospital Association, 45th Annual Convention, Grand Hotel, Mackinac Island

July 30-31—Coller-Penberthy Clinic, Traverse City.

September 20-26—Michigan State Medical Society, Annual Session, Sheraton-Cadillac Hotel, Detroit.

November 14-15—Michigan Allergy Society Midwest Forum, Ford Hospital Auditorium, Detroit.

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MCI In Focus



Above: Registration always goes smoothly at MSMS events. Here Mrs. Dorothy Miller, MSMS secretary, pins badge on H. F. Mullenmeister, M.D., Battle Creek. In the foreground is J. Duane Miller, M.D., Grand Rapids, with R. E. Dustin, M.D., Tecumseh, in light coat.



Above: MCI General Chairman Kenneth H. Johnson, M.D., Lansing, hears William Maier of Smith Kline & French Laboratories explain the SKF color television equipment.



At Left: The evening panel on aging presented, left to right, Jack Rom, M.D., Detroit; Peter J. Steincrohn, M.D., Florida; A. H. Hirschfeld, M.D., Detroit, and A Hazen Price, M.D., Detroit.

Below: The exhibits are keenly studied by, left to right, Wm. S. Bowden, M.D., Marine City; Harry E. Mayhew, M.D., Algonac, and Dale W. Douglas, M.D., Monroe.





At Left: Program details are reviewed by Joseph L. Posch, M. D., Detroit, MCI Program Chairman, and John Heidenreich, M.D., Daggett, one of the general assembly chairmen.



Above: George E. Moore, M.D., right, receives a citation as the Michigan Cancer Coordinating Committee Lecturer from Charles F. Arnold, left, Detroit, and Bernard E. Luck, D.D.S, Lansing, MCCC chairman.

Below: Exhibitor Charles M. Coffman receives his exhibitor's badge from Miss Katie Brewbaker, MSMS Exhibit Secretary and Committee Coordinator. Exhibitors were very pleased with the keen interest shown by Michigan doctors.



Successful MCI



At Right: The MSMS lounge news teletype attracts the attention of K. K. Vining, M.D., left, Grand Rapids, and Ronald Onkin, Senior at Wayne State.

Below: The two MCI evening seminars, open to the general public, drew about 400 each night. Those attending primarily were college students, para-medical workers, volunteer community leaders and teachers.



More MCI Photos



Above: Discussions are lively at the Clinical Round Tables. Left to right are: James W. Logie, M.D., Grand Rapids; Earl G. Krieg, M.D., Grosse Pointe Farms; John J. Coury, M.D., Port Huron; Matthew C. Bennett, M.D., Marquette, and Joseph L. Ponka, M.D., Detroit.



Above: The host at the reception for senior medical students, interns and residents was H. C. Hallum, left, of Mead Johnson. At right, MSMS President Orlen J. Johnson, M.D., meets Ronald R. Larson, president of SAMA chapter at Wayne State.



Above: E. I. Carr, M.D., left, Lansing, President of the Michigan Foundation for Medical and Health Education, presents a citation to the Foundaiton Lecturer, LeRoy G. Augenstein, Ph.D., East Lansing.

Below: Ed Wesley, director of the Smith Kline & French Laboratories TV crew, gets an "assist" from Donald H. Kaump, M.D., Ann Arbor, chairman of MCI Closed Circuit TV Committee.



Above: The Michigan Heart Association presents an address by James C. Paterson, M.D., London, Ontario. The general assembly chairman is Sidney E. Chapin, M.D., Dearborn, and the secretary is Michael C. Kozonis, M.D., right, of Pontiac.

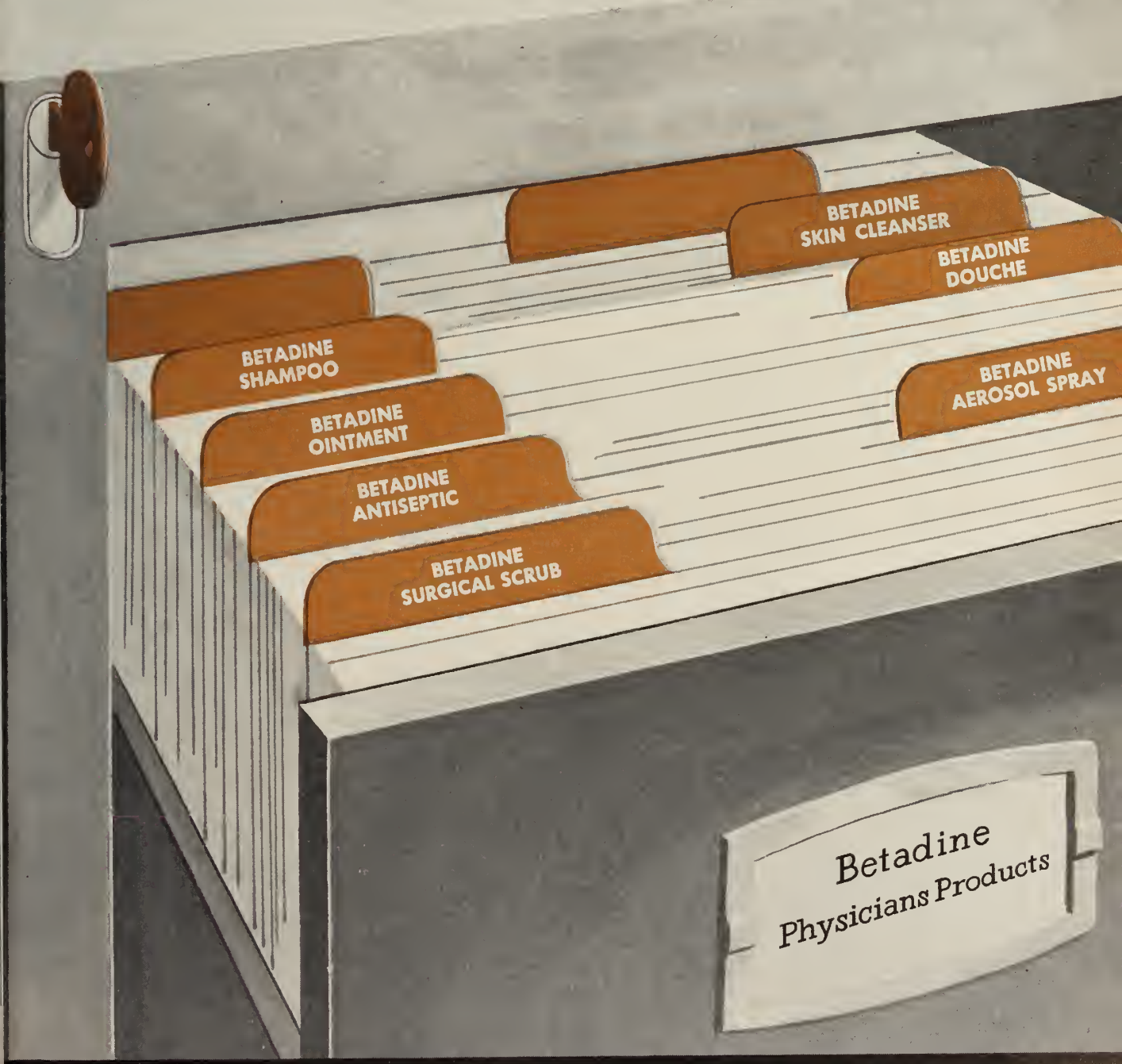


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Betadine Products, in all seven dosage forms, contain povidone-iodine, a complex of polyvinylpyrrolidone and iodine, providing all the germicidal properties of elemental iodine . . . yet Betadine (povidone-iodine) is nonirritating, nonsensitizing, and nontoxic to skin or mucosa.

Betadine Products are effective in preventing and treating a variety of infections frequently encountered in the practice of otolaryngology, orthopedics and orthopedic surgery, obstetrics and gynecology, oral surgery, pediatrics, surgery and dermatology.

The clinical results reported under various conditions of use make Betadine (povidone-iodine) preparations valuable adjuncts both in the hospital and in private practice. Literature available upon request.



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Abstracts of MSMS Council Action

Meeting of March 10, 1964

RECOMMENDATION RE HAZARDS OF CIGARETTE SMOKING

The MSMS Cancer Control Committee requested "The Council to remind all Michigan physicians of the hazards of cigarette smoking and to request all MSMS members to perform a health education service to their patients regarding cigarette smoking by (1) encouraging patients not to begin smoking, and (2) encouraging smokers to stop or curtail their smoking; and further that physicians should be informed regarding the availability of pamphlets and other materials regarding smoking and health which could be distributed in offices and elsewhere." This recommendation of the Cancer Control Committee was adopted by The Council and MSMS members will be so informed.

STATEMENT RE SMOKING LEGISLATION

Upon recommendation of the Legal Affairs Committee, the following statement regarding cigarette smoking was adopted: "Attempts to proceed through legislative action in regard to anti-cigarette smoking should, if possible, be diverted. Instead of legal remedies which may prove of doubtful value, efforts should be made to develop a sound and fundamental educational program."

PLACE OF 1967 MSMS ANNUAL SESSION

The Council decided that the 1967 Annual Session will be held in Grand Rapids providing that suitable dates in September are available. Desired dates in 1967 were not available at the Sheraton-Cadillac Hotel in Detroit.

TRIBUTE TO DECEASED COUNCILOR

The Council paid tribute to the exemplary service of William A. Scott, M.D., Councilor, Fourth District, Kalamazoo, who died February 24, 1964. Information was also received that the Kalamazoo Psychiatric Clinic was establishing a scholarship in memory of Doctor Scott. The Council instructed that information regarding this scholarship be published in The Journal.

ELECTION OF PUBLICATION COMMITTEE CHAIRMAN

Bradley M. Harris, M.D., Ypsilanti, was elected to serve as Chairman of the Publication Committee. The vacancy was created by the death of William A. Scott, M.D.

POLIO IMMUNIZATION POLICY

The Council approved the recommendation of the Interim Committee on Public Health reaffirming the MSMS policy on oral polio vaccine (adopted in January, 1964, by The Council) and recommending that The Council approve the Michigan Department of Health immunization policy dated January 24, 1964. The Council did adopt this recommendation and instructed that each county medical society be informed of the legal responsibilities and liabilities involved in immunization programs.

1964 POSTGRADUATE EXTRAMURAL PROGRAM

The plans of the Postgraduate Medical Education Committee for the spring 1964 extramural program at various centers throughout the state was approved by The Council. Upon recommendation of the Committee, The Council also approved that a representative of Michigan State University be invited to serve on this MSMS committee.

RECOMMENDATIONS FOR FUTURE CONTACT WITH INTERNS AND RESIDENTS

The Planning Committee for the 1964 Residents-Interns-Senior Medical Students Conference, held during the MCI, made recommendation to The Council for future contact with interns and residents, in light of the fact that there will be no future Michigan Clinical Institute. The Council noted that the House of

(Continued on Page 334)



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TRAUMA!

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carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Also available with ¼ gr. codeine as SOMA® COMPOUND WITH CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit forming).

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Side effects: Although there has been no evidence of tolerance, withdrawal symptoms or excessive self-medication, 'Soma' Compound and 'Soma' Compound with Codeine, like other central nervous system depressants, should be used with caution in addiction-prone individuals. While codeine addiction is relatively rare and easily broken, the same precautions must be observed as for any other opium alkaloid. Nausea, vomiting, constipation and miosis are possible codeine side effects. Should symptoms of hypersensitivity occur, discontinue medication.

Contraindications: None reported.

Complete product information available in the product package, and to physicians upon request.

Dosage: Usual dosage is 1 or 2 tablets 4 times daily.

Supplied: 'Soma' Compound is available in orange, scored tablets; bottles of 50. 'Soma' Compound with Codeine (narcotic order form required) is available in white, lozenge-shaped tablets; bottles of 50.

CSO-1054

Abstracts of MSMS Council Action

(Continued from Page 332)

Delegates had authorized the appointment of a new liaison committee with interns and residents and authorized this new committee to study the entire matter of communication and contact with interns, residents and senior medical students and to submit its recommendations to The Council at a future time.

PROGRAM OF THIRD MATERNAL AND PERINATAL WELFARE CONFERENCE

The Council approved the tentative program for this conference, May 14-15, at Gull Lake, Michigan, as developed by the Maternal Health Committee. This will be the third year the Maternal Health Committee has sponsored this successful educational conference.

STATEMENT RE SELECTION OF PHARMACIST

The Council adopted an amended statement proposed by the Liaison Committee with the Michigan State Pharmaceutical Association regarding the selection of a pharmacist, as follows: "It is fundamental that all individuals, whether receiving professional services by private or public means, have freedom to select the pharmacist from whom they receive such services."

LEGAL OPINIONS

Legal Counsel Dodd reported the following opinions: access to hospital records, curtailment of staff privileges, legal consideration re polio immunization, and denial of staff memberships.

QUESTION OF PRESCRIPTION BLANKS CARRYING ADVERTISING

The House of Delegates will be invited to consider the matter of pharmacy advertising printed on physicians' prescription blanks.

REPORT OF SPECIAL SESSION OF THE COUNCIL, MARCH 9, 1964

John J. Coury, M.D., reported on the March 9 meeting with members of the AMA Committee on Osteopathy and Medicine, and The Council and members of certain MSMS and House of Delegates committees. The meeting was for information only and provided excellent background regarding the experience of other states in dealing with the osteopathic question.

REPORT OF MICHIGAN MEDICAL SERVICE

MMS President Sidney Adler, M.D., reported to The Council on five specific items: merit rating, revised billing procedure, radiology-professional service rather than hospital service, anesthesiology, and radioactive isotope procedures. With The Council, Doctor Adler reviewed plans for March 11, when The Council would meet with the Board of Directors of Michigan Medical Service to discuss matters of mutual interest.

SUPPORT FOR LIAISON COMMITTEE BETWEEN MHS AND MMS

The Council agreed to support a proposal of the Michigan Hospital Association that a liaison committee be established between Michigan Medical Service and the Michigan Hospital Association to provide for continuing liaison between the two boards and "whenever feasible, it be the policy of both organizations to discuss matters of mutual interest prior to the adoption of policies relating thereto."

REQUEST FOR LIAISON COMMITTEE WITH MICHIGAN HOSPITAL SERVICE

To improve communication The Council agreed to request the Board of Michigan Hospital Service to appoint members of its Board to a liaison committee to consider matters of mutual interest with the Michigan State Medical Society, the Committee to be composed of members of The Council and the Blue Cross Board. When such committee is appointed, The Council recommended that the matter of reverification policy of Michigan Hospital Service be an item on the agenda.

EXTENDED BENEFITS FOR MSMS DISABILITY INSURANCE PLAN

Upon recommendation of the Committee on Professional Insurance Plans, The Council authorized that extended benefits be offered to MSMS members participating in the disability insurance plan, as an option.

(Continued on Page 336)



15 mm. Hg. was the average diastolic drop reported following use of HYDROMOX Quinethazone in recent studies of patients with various hypertensive diseases, including essential hypertension and hypertension associated with arteriosclerotic heart disease, obesity, and renal disease.[1,2] The treatment period in one study was eight weeks[1] and in the other, twelve.[2] The lack of serious disturbances in serum electrolyte levels, particularly of potassium, was noteworthy. In fact, it was considered a sufficiently important factor to give the drug a preferential status.[2] A single daily dose of one to two 50 mg. tablets is usually sufficient.

ANTIHYPERTENSIVE DIURETIC **HYDROMOX®**
QUINETHAZONE·TABLETS

1. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962. **2.** Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

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Abstracts of MSMS Council Action

(Continued from Page 334)

BUDGET OF STATE BOARD OF REGISTRATION IN MEDICINE

The State Board of Registration is seeking an increase in its annual budget to provide better investigation services. The support of MSMS in this request was sought. The Council agreed to support the efforts of the State Board to increase its budget, upon review of the budget by the Legal Affairs Committee.

ATTENDANCE AT COUNCIL MEETINGS OF DIRECTOR OF STATE DEPARTMENT OF MENTAL HEALTH

The MSMS Mental Health Committee recommended that the Director of the Michigan Department of Mental Health be invited to attend regularly the meetings of The Council. The Council agreed to invite the Director of the Department of Mental Health at appropriate times depending upon agenda items to be discussed.

PARTICIPATION IN SAGINAW COUNTY FAIR

Upon request of the Saginaw County Medical Society, The Council authorized that $300 be allocated from the public relations budget to help defray costs of the Saginaw CMS exhibit at the Saginaw County Fair.

COMMITTEES APPOINTMENTS

Liaison Committee with Michigan Crippled Children Commission: A. Carl Stander, M.D., Saginaw, Chairman; Charles H. Frantz, M.D., Grand Rapids; Louis E. Heideman, M.D., Detroit; Robert M. Leitch, M.D., Union City; Frank V. Schoick, M.D., Jackson; and Francis P. Walsh, M.D., Detroit.

Committee on Retirement Plan: R. K. Whiteley, M.D., Detroit, Chairman; Mr. Lester P. Dodd, Detroit; W. M. LeFevre, M.D., Muskegon; J. J. Lightbody, M.D., Detroit; and R. V. Taylor, M.D., Jackson.

EXECUTIVE DIRECTOR'S REPORT

Mr. Hugh Brenneman presented a report on use of MSMS headquarters, staff personnel, program for County Secretaries-Public Relations Seminar, and other MSMS activities.

Mass Media Help Promote County Oral Polio Efforts

The newspapers, radio stations and television stations of Michigan have been most generous in their news coverage and editorial support of the oral polio vaccine campaigns under way this spring across the state.

The media, too, has been very complimentary about these efforts of the county medical societies in sponsoring such mass vaccination projects.

Typical of the editorial comments is this one from the Jackson *Citizen-Patriot*, which in part stated:

"The Medical Society deserves the thanks of the people for making this project possible. Here the doctors are living up to the very highest traditions of their profession. They are underwriting the cost of the vaccine and are donating their services. While they are asking a small voluntary contribution (50 cents per person is suggested) to help defray the cost, no one will be turned away for lack of funds.

"Thus is being written another chapter in the thrilling story of the conquest of one of mankind's worst diseases."

Attention Doctors!

The MSMS Cancer Control Committee, with the approval of The MSMS Council, presents the following message:

"All MSMS members are reminded to perform a health education service to their patients regarding cigarette smoking by 1) encouraging patients not to begin smoking and 2) encouraging smokers to stop or curtail their smoking; and further, physicians should be informed regarding the availability of pamphlets and other materials from MSMS regarding smoking and health which could be distributed in offices and elsewhere."

(Turn to Page 338)

SHEDD'S SAFFLOWER MARGARINE

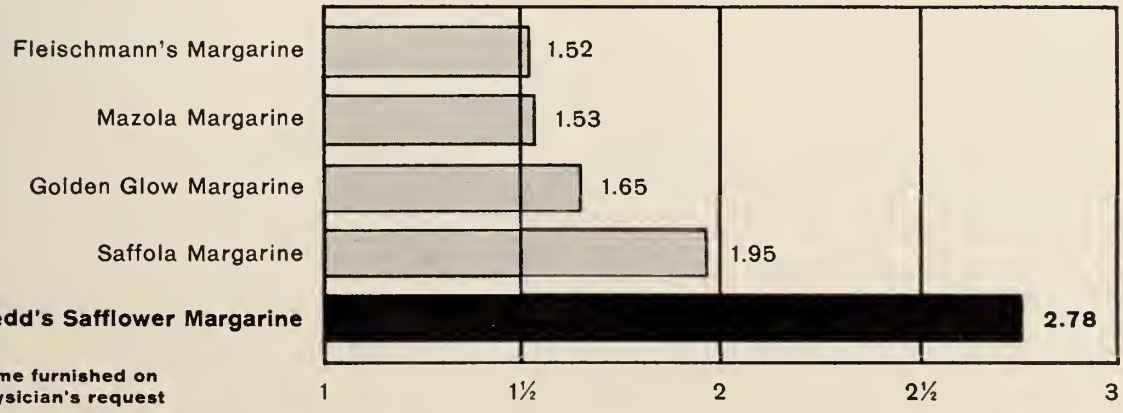


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in ratio of poly-unsaturates to saturated fats

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THE RESULTS OF THIS TEST PROVED SHEDD'S SAFFLOWER MARGARINE HAS A HIGHER RATIO OF POLY-UNSATURATES TO SATURATED FATS.



*Name furnished on physician's request

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Detroit 24, Michigan
General Practice

Charles E. Black, M.D.
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Monroe, Michigan
Obstetrics and Gynecology

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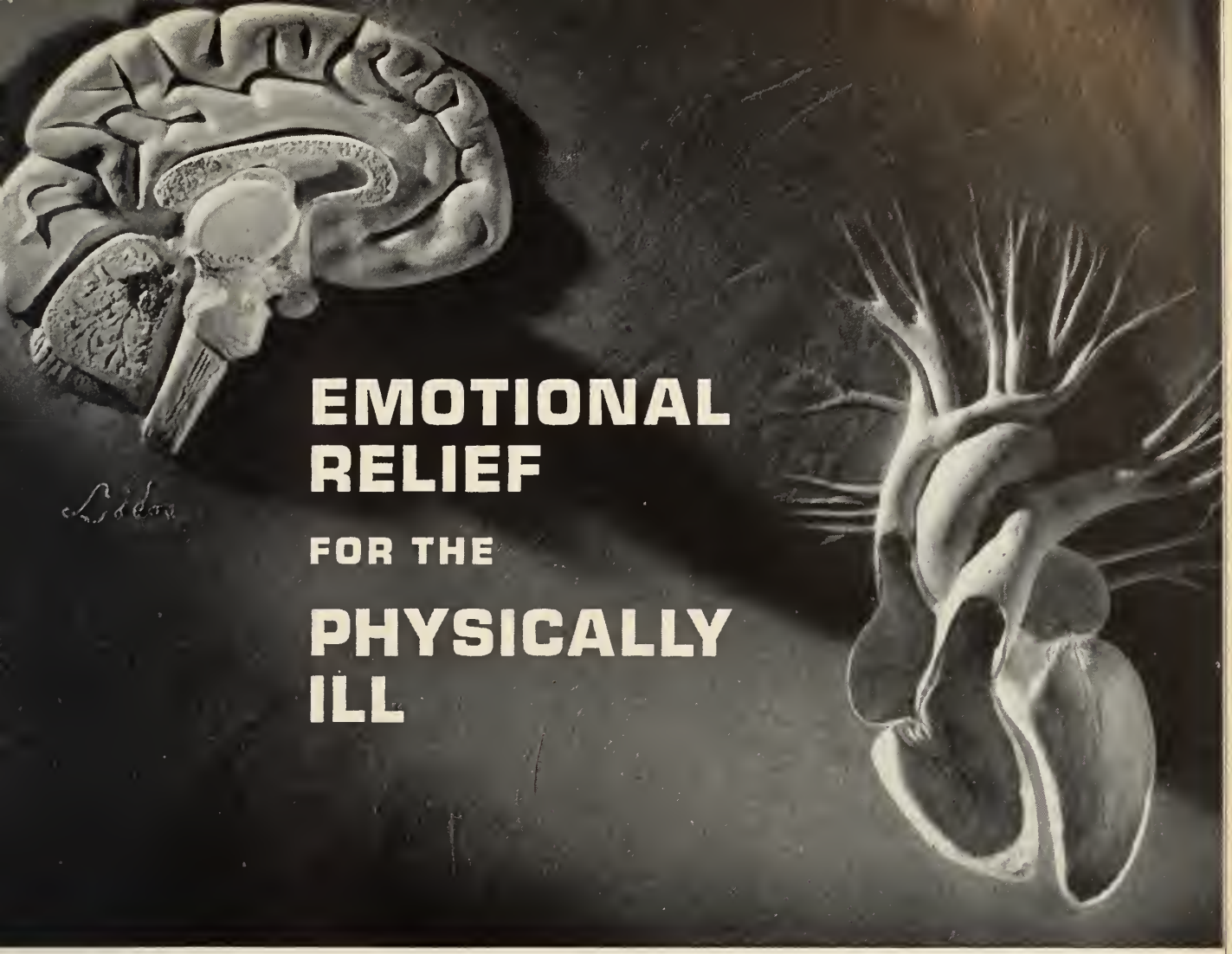
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. . . keeps the patient calm, and the mind clear.



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(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

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Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-760

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for the
patient with
'pain &
spasm'

pain *is almost invariably a presenting symptom in cases of skeletal muscle* *spasm*

In some instances, the pain subsides on relaxation of the muscles in spasm. In others, relaxant therapy alone fails to give adequate relief, and supplementary analgesia (and possibly sedation) are indispensable, as in cases of:

provocative pain, when muscle spasm is triggered by some painful underlying musculoskeletal defect.

residual pain, when relaxation of severe spasticity leaves a degree of myalgia that tends to reinvoke spasm.

severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

emotionally aggravated pain, when anxiety or agitation creates tension that thwarts the efficacy of both relaxant and analgesic medication.

In such cases, ROBAXISAL and ROBAXISAL-PH have proven highly effective in assuring decisive and comprehensive relief. The ROBAXISAL formula—of ROBAXIN (methocarbamol), the potent muscle relaxant, together with aspirin, the time-tested and proved analgesic—produces higher plasma salicylate levels than equivalent doses of aspirin alone, and serves effectively to control both spasm and pain. ROBAXISAL-PH's combination of ROBAXIN (methocarbamol) with the analgesic-sedative ingredients of the PHENAPHEN formula—including phenobarbital—helps additionally to ease apprehension.

ROBAXISAL®

Robins

Each pink-and-white laminated Tablet contains:
ROBAXIN (methocarbamol, Robins) .....400 mg. Aspirin (5 gr.).....325 mg.
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Each green-and-white laminated Tablet contains:
ROBAXIN .....400 mg. (methocarbamol, Robins)
Phenacetin (1½ gr.)....97 mg.
Aspirin (1¼ gr.).....81 mg.
Hyoscyamine sulfate 0.016 mg.
Phenobarbital (⅛ gr.)....8.1 mg.
(Warning: May be habit forming)



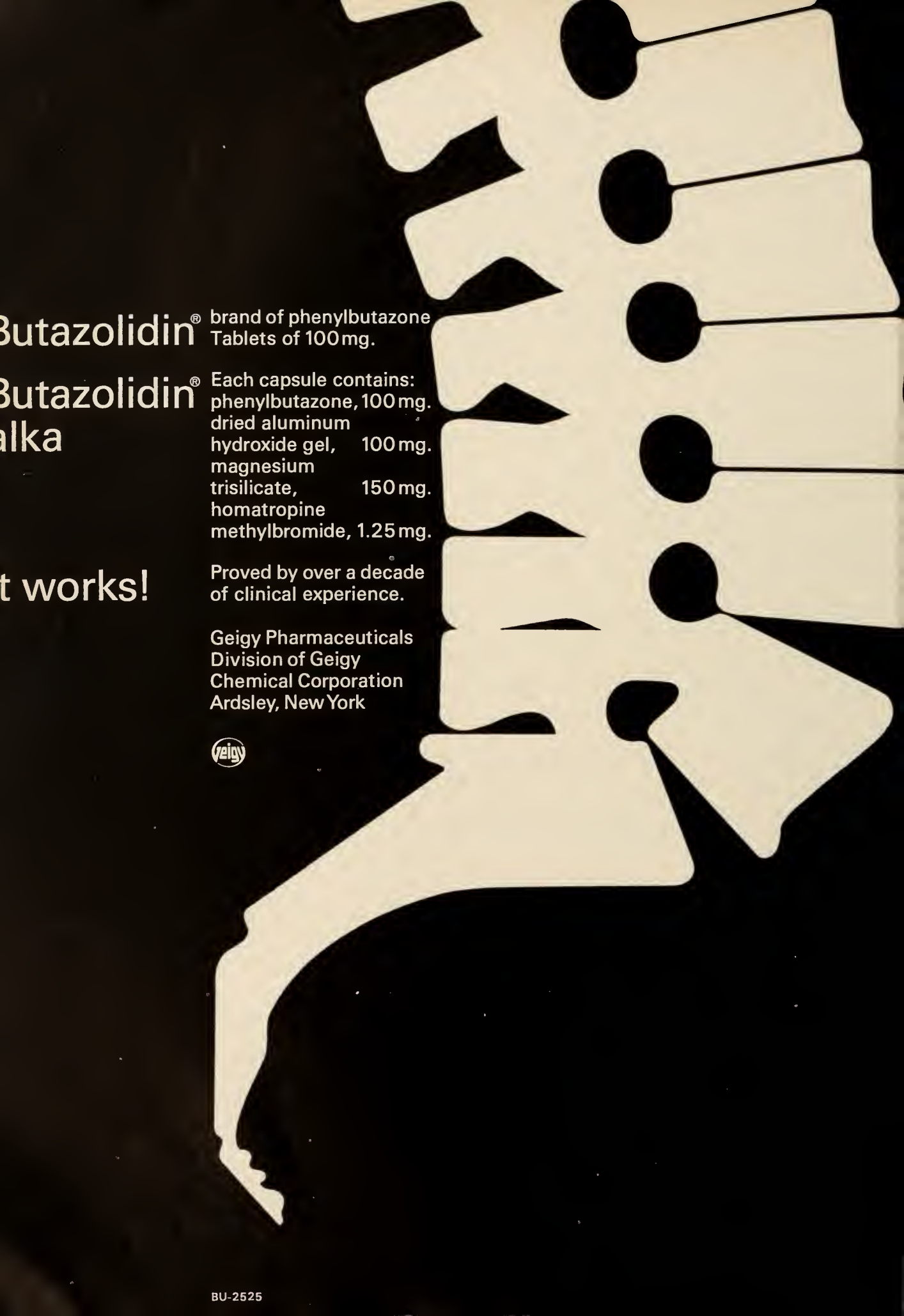
"PAIN & SPASM"
–a two-headed dragon!

ROBAXISAL and ROBAXISAL-PH are indicated in strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with intolerance to drugs, but they usually disappear on reduction of dosage.

Contraindicated for patients hypersensitive to any component of the formulations. There are no specific contraindications to methocarbamol, and untoward reactions are not to be expected.

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Tablets of 100 mg.
Each capsule contains:
phenylbutazone, 100 mg.
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County Society Projects Serve the Public

Spring always is a busy time as county medical societies sponsor projects to serve the public.

Following are some brief digests from Michigan newspaper stories:

Eaton Does Screening

Doctors in Eaton County are cooperating in a Health Screening Test program. All Eaton residents 21 or older may avail themselves of the tests, to uncover tuberculosis, diabetes, heart disease and other chronic illnesses.

Hillsdale Helps Evaluate

Members of the Hillsdale County Medical Society are participating in a free rehabilitation evaluation clinic. A doctor may recommend that his patient utilize the clinic, where the examining team consists of a physician specializing in rehabilitation, an occupational therapist and a physical therapist.

The clinic, coordinated through the University Hospital, Ann Arbor, Department of Physical Medicine and Rehabilitation, saves patients the trip to larger centers away from home.

Genesee Has 'Alcoholism Day'

The Genesee County Medical Society sponsored an 'Alcoholism Day' program with C. K. Stroup, M.D., as chairman. Genesee President Dira E. Branch, M.D., reports "to my knowledge, this is the first time that a medical society has sponsored a day to provide discussion and information on this important subject." The MSMS Committee on Alcoholism and Drug Addiction, Richard C. Bates, M.D., chairman, held a meeting in Flint on the same day.

Kent Boosts Libraries

The 14 branches in the Kent County Library system will be offering the latest in medical and science books, which appeal to the general public, thanks to a recent $200 gift from the Kent County Medical Society.

"We are most grateful to the Kent County Medical Society," Joyce Pleune, librarian, stated in announcing the gift.

For many years the Society has given a similar gift to the Grand Rapids Public Library. This year the Library Committee of the Medical Society of which William Vis, M.D., is chairman, recommended that a like amount be given to the County Library to benefit County Library patrons also.

No restrictions are placed on the gift, except that the selections should be in the field of medicine and science and should appeal to the general public.



Have *You* Written Your Congressman?

Operation Hometown

GOAL

5,000 letters from each Congressional District

WHY

To counter an all-out drive by the Johnson Administration to pass Fedicare this election year

WHAT TO DO

Write to your own Congressman and urge your colleagues, friends, and patients to do the same



Do It Now..Write *Today*

Supporters of socialized medicine are hard at work. Are you?

Three Societies Cooperate In Tri-County Polio Effort

Following a successful first-dose operation, the county medical societies of Wayne, Oakland and Macomb are preparing for the second Sunday distribution on June 14. An estimated 1,800,000 persons received the first dose at 667 oral polio vaccine stations on April 19. Members of the three county medical societies, pharmacists, nurses, other health personnel and many lay volunteers worked to distribute the first sugar cubes. Chairmen for the tremendous undertaking are Francis P. Rhoades, M.D., Wayne County; Robert M. Bookmyer, M.D., Oakland County, and Gerald W. Morris, M.D., Macomb County.



F. P. Rhoades, M.D.



R. M. Bookmyer, M.D.



G. W. Morris, M.D.

While the three metropolitan county medical societies united for the one coordinated effort, many other medical societies across the state also conducted oral polio vaccine campaigns.

Maternal-Perinatal Welfare Conference Set May 14-15

A capacity registration of 100 Michigan doctors will participate in the Third MSMS Maternal and Perinatal Welfare Conference, May 14-15.

Once again, the event will be held at the pleasant MSMS conference facility at Gull Lake, on the grounds of the Kellogg estate.

W. W. Jack, M.D., Grand Rapids, chairman of the MSMS Maternal Health Committee, will open the event, along with Orlen J. Johnson, M.D., Bay City, MSMS President.

Joining to co-sponsor the event are the Michigan Department of Health Division of Maternal and Child Health, and MSU.

Outstanding medical authorities from Michigan and the nation are listed on the program.

Say you saw it in the Journal of the Michigan State Medical Society



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

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GERIATRIC
antiarthritic
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REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention... the enteric coating assures gastric tolerance... and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

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In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium para-aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

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release for hostility?

Overeating is often an outlet for feelings of hostility. Many people take out their anger by overindulgence at or between meals. As a result they become overweight.

'Eskatrol' *Spansule* capsules both control appetite and relieve the emotional stress that causes overeating. That's why so many patients are losing more pounds with 'Eskatrol'.

ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules

because emotions play an important role in overweight

Brief Summary of Principal Side Effects and Cautions

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory. *Cautions:* 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

For complete prescribing information, please see *PDR* or available literature.

Supplied: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F

Say you saw it in the Journal of the Michigan State Medical Society

Latest Available Data on Health Insurance

Michigan—the pioneer state in prepaid medical care—has reached a high level in health insurance protection.

Some 82 per cent of Michigan's population was covered by some form of health insurance by the end of 1962. The national average for hospital and medical care coverage, excluding the military, is 76 per cent.

More than 6,593,000 Michigan residents had hospital expense insurance and 6,355,000 had surgical expense insurance. Regular medical expense insurance covered some 5,334,000 Michigan residents. 1,432,000 persons had major medical insurance protection. These figures represent the net total of people protected to eliminate duplication among persons protected by more than one kind of insuring organizations, or more than one insurance company policy providing the same type of coverage.

The 284 licensed health insuring organizations in Michigan paid out $414,840,000 in claims in 1962. Comprising these 284 insuring organizations are 267 insurance companies, four Blue Cross-Blue Shield and similar groups and 13 other health plans.

Some 1962 statistics on hospitals and professional services in Michigan are as follows:

Hospital Statistics

Number of nonfederal, short-term general and other hospitals	195
Number of hospital beds available	27,544
Number of persons admitted during 1962	1,022,659
Number of persons under hospital confinement on an average day	22,358
Average length of time patient remained in hospital	8 days
Average cost per hospital stay	$318.92

Professional Services

Number of practicing physicians	6,081
Number of practicing dentists	4,245
Number of registered pharmacists	5,300

We are indebted to the Health Insurance Institute for this information. These 1962 figures represent the latest available data.

Materials for the Medical Socio-Economic Section are provided by Richard M. Campau, MSMS Research Director.

Cash-Only Benefits from Social Security Favored by US C of C

MSMS officers have been critical of all other Fedicare proposals related to the Social Security taxes because the government then would no longer give only cash Social Security benefits but also service benefits. The MSMS argument was effectively presented before the House Ways and Means Committee in Washington by the Chamber of Commerce of the United States. The Chamber had sent a questionnaire to its business members and the replies showed that 93.2 per cent believed that "social security benefits in cash only is a sound principle."

The Chamber spokesman also stressed that the health needs of the elderly can be—and are being—met through voluntary private insurance plans, existing government programs and the Kerr-Mills act.

Survey Finds Businessmen 3-1 Against HR 5220

Independent businessmen are opposed 3-1 to HR 5220 which is a bill to provide government help to retired people towards paying for private hospital programs.

The National Federation of Independent Business announces that its recent opinion poll found that 71 per cent were against HR 5220, 25 per cent were for and 2 per cent undecided.

More Women Entering Medical Schools

Over the past 30 years, the percentage of women entering medical schools compared to the total enrollment has risen from 4.5 to 8.5.

While the number of male applicants has remained remarkably steady except for a period immediately after the war years, the number of female applicants has gradually increased.

The number of medical degrees awarded to women over the past nine years has remained fairly constant at 5 per cent of the total number of medical degrees granted—a figure that is low for our manpower needs.



"Leakers" are ampoules with minute imperfections in the seal. You can't readily see the flaw, and often it's so small that liquids won't even drip through; but microscopic contaminants can slip in to render the contents nonsterile and potentially dangerous. ▪ Detecting "leakers" is the job of the vat and the blue dye. ▪ Sealed Lilly ampoules are placed in baskets, submerged in a vat containing methylene blue, and subjected to a vacuum. If there is an imperfect ampoule in the lot, the liquid is forced out. When the vacuum is released, the blue dye rushes in. ▪ With dye as the spy, elusive "leakers" are quickly spotted and rejected . . . another of the many controls that add immeasurably to the quality of the finished product.

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Prolonged use of topical steroids is capable of producing glaucoma in a significant number of patients.

Steroid Induced Glaucoma

Leonard H. Lerner, M.D., Lawrence L. Stocker, M.D., Robert I. Gans, M.D.
Detroit, Michigan

IN 1952, Tillett[1] reported on a group of 15 patients who were on ACTH treatment. He found no significant effect upon the intra-ocular pressure. In 1954, Francois[2] reported the remarkable case of a 35-year-old man who had been treated by topical steroids for three years for vernal conjunctivitis who had bilaterally white eyes and very markedly elevated intra-ocular pressure; one eye was operated on for the pressure elevation, the other pressure decreased to normal with the discontinuation of the topical steroid therapy. Unfortunately, this article appeared in French and was not widely noted by the English speaking ophthalmologists. Laval and Collier, in 1955, reported three cases of ocular sarcoidosis which were treated with local steroids and/or ACTH gel that showed very significant increase in the intra-ocular pressure related to ACTH and steroids.

In 1958, Lee reported no evidence of increased intra-ocular pressure or impaired facility of outflow in a group of 13 patients on long-term systemic steroid therapy for severe asthma. In the same year, Koval reported three cases suggesting in the title that the glaucoma noted in these three patients was induced by systemic steroid therapy. However, each of these patients was elderly, one was probably a narrow-angle mechanism, and all three responded very well to topical Pilocarpine therapy. Harris, in 1960, reported a case of a 37-year-old white man who had received corticosteroids for seven years and who developed a glaucoma so severe that he required bilateral filtering operations. However, in this instance, the angles were found to be narrow with some peripheral anterior synnechiae.

In 1962, Goldman[3] reported five cases all in female patients and all, with the exception of one, quite young, who had been using steroid drops for a long period. They had white eyes and a very markedly elevated intra-ocular pressure. None showed evidence of any intra-ocular inflammation and all patients were distinctly improved with the discontinuation of the steroids. However, in only one did the pressure return completely to normal and, unfortunately, several cases could not be personally followed by him. In 1962, Smith, Stempfel, Campbell, Hudnel, and Richmond reported the diurnal variations of plasma 17-hydroxy-corticoids and the intra-ocular pressure, to be fairly well directly correlated. In 1963, Lerman reported two cases of endophthalmitis treated (in addition to the antibiotics used) with steroids, showing distinct elevations of the intra-ocular pressure in the affected eye associated with the steroid therapy. Bernstein, Mills, and Becker,[4] in 1963, reported a case of a 25-year-old female patient with disseminated lupus erythematosis who had been receiving systemic steroids for one year and was found to have an increased intra-ocular pressure and decreased facility of outflow. The facility of outflow increased moderately and the intra-ocular pressure fell significantly with the reduction of steroid level. With the addition of steroid topically, the intra-ocular pressure again rose and the facility of outflow decreased.

Alfano, in 1963, reported three cases. The first was a patient on long-term steroid therapy for arthritis who had an elevated intra-ocular pressure which fell when given medication which caused diuresis. The second case was a patient with controlled open-angle glaucoma in whom an intra-ocular elevation of pressure occurred when she was started on oral steroid therapy for bursitis and arthritis. The withdrawal of the steroids resulted in a prompt return of the pre-steroid intra-ocular pressure level. The third case was that of a white woman with chronic multiple sclerosis and open-angle glaucoma in whom steroid therapy for recurrences of the multiple sclerosis coincided with distinct elevations in the intra-ocular pressure.

Armaly[5,6] and Becker,[7] in 1963, reported the effect of topical corticosteroids in both the normal and glaucomatous eyes. They both found that in apparently

From the Department of Ophthalmology, Sinai Hospital of Detroit, Detroit, Michigan, and Wayne State University, Detroit, Michigan.

normal eyes, a significant percentage showed a significant increase in the intra-ocular pressure. In the known glaucoma patients and those with suspicion of glaucoma, there was a large and very significant rise in the intra-ocular pressure.

Three recent cases from our practice are good examples of the pressure elevating effect of topical steroids.

Case 1.—The patient was a 53-year-old white man, a boring-mill operator. He was first seen on May 28, 1963. His best corrected vision was 20/25—1 on the right and 20/60—1 on the left. He complained of bilateral redness of the eyes of one day's duration. Examination revealed non-specific subconjunctival hemorrhages bilaterally. He reported that he had been troubled by such recurrent redness for a number of years and had generally red eyes for approximately ten years. He had first seen an ophthalmologist five years previously who had not checked the pressure. On initial examination, his tension measured 3/2 with a 10 gram weight (50/59). He had a moderate posterior subcapsular cataract on the left, equivalent to the vision. He had bilateral shallow physiologic cups, slightly deeper on the left. Gonioscopy revealed a very deep open-angle bilaterally, without sign of excessive pigmentation. For approximately two years, he had been using topical steroids. They had first been prescribed by an ophthalmologist who had checked his tension and who had prescribed topical cortisone which he had been using two to three times per day since that time. He had variously used Neo Delta Cortef, Prednefrin, and Neo Hydeltrasol. All topical steroids were stopped and the patient was seen again on June 4, 1963.

The tension measured 3/3 with a 7.5 gram weight (35/35). Tonography revealed an outflow co-efficient of .10 on the right and .12 on the left. Central fields revealed a normal right field and only a very slightly enlarged blind spot on the left. On June 11, 1963, the tension was 4.5/4.5 with a 7.5 gram weight (28/28). Applanation tonometry then was 30/32. On June 19, 1963, the tension had dropped to 26/27 by applanation tonometry. By June 25, 1963, the vision in the right eye had risen to 20/15—1 and on the left, the best corrected vision was 20/200+2. The tension was 23/22 by applanation tonometry. By July 2, 1963, the tension was 23/20. On July 23, 1963, the tension was 24/20. The outflow co-efficient was right .12 and left .14. When seen on August 20, 1963, for a water test, the initial tension was 4.5/5.0 with a 5.5 gram weight and there was no significant change due to the water.

Case 2.—The patient was a 21-year-old white man, a welder, who was first seen in March of 1962. He had gotten caustic in his right eye in December of 1961, and had been treated with steroids, but a large pseudopterygium with corneal ulcer resulted. Under local anesthesia on June 5, 1962, the pseudopterygium was excised. Postoperatively, the patient was placed on Prednefrin, O. D., q.i.d. His progress was essentially uneventful, but he continued to use the Prednefrin until July 20, 1963, at which time, for the first time, the intra-ocular pressure was measured. It measured 3/6 with a 5.5 gram weight. The steroid was immediately discontinued. By August 26, 1963, the intra-ocular pressure had fallen to 7/7 with a 5.5 gram weight. On September 14, 1963, applanation tonometry revealed a tension of 15 on the right and 14 mms. on the left. Gonioscopy revealed deep open angles throughout without any sign of abnormality. Tonography revealed a C on the right of 0.20 and on the left, the C was .40.

Case 3.—The patient was a 33-year-old white woman, a metal press operator. When first seen on July 24, 1961, her best corrected vision was 20/20 on the right and 20/15 on the left. History included flashburns by a welding machine five months previously. She had bilateral pterygia which were excised under local anesthesia on August 15, 1961. The patient was placed on Prednefrin drops O. U., q.i.d. On December 16, 1961, the pressure was noted to be soft by tactile tension only. She was continued on Prednefrin O. U., b.i.d., which was continued until October, 1962, at which time it was reduced to one drop O. U., q.h.s. On June 3, 1963, the intra-ocular pressure measured 2/1 with a 5.5 gram weight and the use of the steroids was discontinued. A water test done on July 1, 1963, revealed a negligible rise in the intra-ocular pressure under the influence of the water consumed. The starting pressure was 5/5 with a 5.5 gram weight. The pressure rose only as high as 4/4 with a 5.5 gram weight. It promptly fell to 5/5 with a 5.5 gram weight where it remained. On September 14, 1963, applanation tension was 16 mms. on the right and 18 mms. on the left. Gonioscopy revealed open angles 360 degrees without sign of abnormality. Tonography revealed C on the right to be 0.22, and on the left, 0.26.

Discussion

Until very recently, most well trained and prudent ophthalmologists felt that the topical use of the steroids was only contra-indicated in the presence of herpes simplex virus and/or fungus infection. With the above three cases added to the previously published literature, it is strongly suggested that another iatrogenic disease is glaucoma induced by the use of the corticosteroids.

Summary

Three cases are presented which are strongly indicative that topical steroid can be responsible for the induction of elevated intra-ocular pressure.

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The authors are on call 24 hours a day with the law enforcement agencies for the investigation of fatal automobile accidents in Washtenaw County, Michigan. The results of a detailed personal investigation of 79 deaths in automobile accidents are presented with special emphasis on correlating patterns of injury of the victims with patterns of damage to the vehicle. Thirty-four per cent of the victims would have been saved by a simple lap-type seat belt. The value of the seat belt in both front and rear seats is emphasized. Certain features of the interior design of automobiles contribute to fatal injuries in automobile accidents. The superiority of the shoulder strap lap-belt combination over the simple lap-belt for front seat occupants is also discussed.

Causes of Deaths In Automobile Accidents

Can Seat Belts Really Save Lives?

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ACCIDENTS are exceeded only by heart disease, neoplasms, and strokes as a cause of death in the United States. More than 90,000 persons are killed in this country annually by accidental causes. Of the 41,000 killed in motor vehicle accidents in 1962, approximately 27,000 were drivers or passengers in motor vehicles. In addition, about 1,500,000 persons were injured in automobile accidents the same year.[1]

These statistics identify the motor vehicle accident as a major public health problem in this country. The tragedy of this annual slaughter on our roads is compounded by the fact that most of these deaths are preventable. There are two obvious means for reducing this death toll. One approach, of course, is to reduce the number of accidents. This requires proper maintenance of motor vehicles, proper design and maintenance of roads, strict enforcement of sensible traffic laws, maximum driver skill and alertness, only to mention a few of the many facets of the accident prevention program. The authors believe that, in spite of the above-mentioned steps, it is only realistic to assume that as long as a human being is in control of a motor vehicle, there is a potential accident situation.

The second approach is to employ measures to reduce fatal injuries in the event one has an automobile accident. The purpose of this study concerns itself with this latter approach. To determine what measures are necessary to prevent fatal injury in an automobile accident, one *must* know the exact cause of death and the means by which the fatal injury was inflicted.

In order to collect this information, the authors have arranged with the law enforcement agencies and the medical examiner's office in Washtenaw County, Michigan, to be called to the scene of all fatal automobile accidents in the county. The two authors serve as co-principal investigators. A personal thorough investigation at the scene is made, and detailed information concerning the collision course, the position of the vehicle or vehicles, location of victims, and pattern of exterior and interior damage to the vehicle is collected. A detailed external examination of the victim is made

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and, when proper permission is granted, a necropsy is performed. The pattern of injury of the victim is then correlated with the pattern of damage and interior design of the vehicle. From this information, the position of the victim at the time of the impact and the path traveled by the body is determined, and postulates are then made as to the mechanism of infliction of the fatal injury.

This study has been in progress for 23 months, and a total of 79 deaths in 57 accidents have been investigated. Necropsies were performed on 55 per cent of the victims. In this series the driver-at-fault was the most frequent victim. This group was followed in frequency by passengers in the at-fault car. Infrequently passengers or drivers in the innocent car were killed (Table I).

TABLE I. INDIVIDUALS KILLED
79 Fatalities

Driver at fault	57%
Passenger in at-fault car	30%
Innocent in another car	13%

There were 44 single fatality accidents, six accidents in which two individuals were killed, five triple fatality accidents, and two accidents in which four persons died in each accident.

Early in the study, it became apparent that certain victims could have been saved if a lap-type seat belt had been used. In order to determine whether a seat belt would have been effective in preventing the fatal injury, a careful inspection of the driver and passenger compartments is made and the victims are projected into their respective positions at the time of the accident. If adequate occupant space remains, that is, little or no deformation or compromise of the compartment in which the victim was sitting, then survival is deemed possible, providing the threshold for G-force tolerance was not exceeded. This latter criterion of G-force tolerance is more difficult to establish; however, using data from planned collisions by the automobile manufacturers and the Institute of Traffic and Transportation Engineering of the University of California at Los Angeles, it is predicted from the amount of vehicular deformation that the level of survivability was or was not exceeded. It is realized that the determination of speed at impact in an accident situation is at best often only an approximation obtained from witnesses and police officers. In some of the situations, however, some of the occupants of the vehicles involved in the accidents survived and thus are considered as living controls. Additionally, vehicular damage is compared to that obtained from the above-mentioned planned car crashes and estimates of relative speed at impact are made.

In accident situations in which the victims would have been saved by a simple lap-type seat belt, the fatal injury was produced by either ejection from the vehicle with fatal injury received outside of the car, or by the victim being thrown against some structure in the interior of the vehicle. The latter phenomenon is referred to as the secondary collision between the victim and the interior of the vehicle. Twenty-seven (34 per cent) of the 79 victims were ejected from their vehicles. As a result of applying the criteria mentioned above, it was determined that 63 per cent of those victims ejected would have been saved with a lap-type seat belt. Another 8 per cent would have been saved with the shoulder strap lap-belt combination. It was determined that in 21 per cent of the ejectees, survival within the car was impossible due to destruction of the occupant area of the vehicle. In certain cases (8 per cent) we could not determine with certainty whether survival would have been possible had the victim been retained in the automobile (Table II).

TABLE II. VICTIMS EJECTED FROM AUTOMOBILES
27 (34%) of 79 Victims

	Number	Per cent
Saved		
With Seat Belts	17	63
With Shoulder Harness	2	8
Not Saved	6	21
Unknown	2	8
	27	100

When the criteria are applied to all of the victims, whether they were killed by a secondary collison within their car or whether they were ejected, it was found that a minimum of 34 per cent of these victims would have survived if the lap-type seat belt had been used. The figure of 34 per cent survival with a lap-type seat belt compares favorably with the results of the study by Tourin and Garret in 1960, utilizing data collected by the California Highway Patrol. Their study showed that the use of the seat belt could be expected to reduce the incidence of major-to-fatal grades of injury by approximately 35 per cent.[2] An additional 11 per cent of all fatalities in our study would have survived with a shoulder strap-seat belt combination. Forty-seven per

TABLE III. EFFECTIVENESS OF SEAT BELTS IN ALL ACCIDENTS INVESTIGATED

57 Accidents	79 Fatalities	
Saved		
With Seat Belts	34%	Minimum
With Shoulder Harness	11%	
Not Saved	47%	
Unknown	8%	
	100%	



Fig. 1. Instrument panel with blood stain adjacent to knob mounting.

cent were in an unsurvivable situation due to severe destruction of the occupant compartment. In 8 per cent of the fatalities, survivability could not be predicted (See Table III).

In certain situations, it is believed that the shoulder strap-lap belt combination would be more effective in preventing the fatal injury than only the lap-type seat belt. This is due to the fact that a tall individual may flex and strike the instrument panel with his head even when wearing the seat belt. This is particularly true in compact automobiles. Also, seat belts stretch on sudden deceleration and this may allow the victim to strike his head against an interior structure of the automobile. The steering wheel and post are also significant objects for inflicting fatal injuries. A lap-type seat belt often would not prevent collisions between the victim and these objects. A shoulder strap-lap belt combination would in some instances prevent or buffet this collision. It is in these situations that the shoulder strap-lap belt combination may be the determining factor for survival.

It was noted in this series that certain features of interior design of automobiles, particularly knobs and the contour of instrument panels, have a significant influence on the type of fatal injury. In one case a radio knob served as the instrument of infliction of the fatal injury. The victim's head struck the knob and it penetrated the calvarium and entered the frontal lobe of the brain (Figs. 1 and 2). In other accident situations, sharp edges on instrument panels or levers inflicted the fatal injuries (Figure 3). We believe that seat belts are equally important in the rear seats, since some of the victims in this study were catapulted from the rear seat into the instrument panel (Figure 3) or they were ejected from the automobile. In one instance a passenger was ejected from the rear seat of a two-door car and killed.



Fig. 2. Roentgenogram of skull showing control knob within cranial cavity.

Conclusions

Ejection from a motor vehicle plays a significant role in the mechanism of the fatal injury sustained by victims in automobile accidents. Victims who were not killed by ejection received their fatal injury from the secondary collision between them and some structure in the interior of the vehicle. A simple lap-type seat belt is an effective means for preventing ejection from the vehicle, and it lessens the severity of the impact or may entirely prevent the secondary collision between



Fig. 3. An adult received a fatal fracture of the larynx on impacting the sharp protruding edge of the instrument panel. A child received a fatal mandibular fracture on impacting the panel producing the triangular depression. The child catapulted from the rear seat.

the victim and interior structures of the vehicle. Certain characteristics of the interior design of the vehicles may contribute to the fatal injury, such as protruding knobs, sharp contours on instrument panels, and other features.

Summary

The results of a detailed personal investigation of 79 deaths in automobile accidents are presented with special emphasis on correlating patterns of injury of the victims with patterns of damage to the vehicle and occupant compartment. This correlation was also applied to ejection or retention within the vehicle. We believe that a minimum of 34 per cent of the victims would have survived if a simple lap-type seat belt would have been worn. Another 11 per cent would have probably survived with a shoulder strap-lap belt combination. The influence of certain features of the interior design of motor vehicles on the type of fatal injury is discussed.

Acknowledgments

We are indebted to Dr. Otto K. Engelke, Chief Medical Examiner, Washtenaw County, the Michigan State Police, the Ann Arbor Police Department, and the Washtenaw County Sheriff's Department for their cooperation which made this study possible.

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Studies of Experimental Skin Donor Sites

The healing of 48 split-thickness donor sites in 24 male volunteers was studied by examining biopsy specimens taken at intervals of one or two days. In all, 144 specimens were examined.

The observations and data obtained indicate that two processes are mainly involved in the healing of donor sites. Epithelization takes place from the surrounding epidermis and from hair follicles and sweat ducts. The removed dermis is replaced, at least partially, by local connective tissue proliferation. During the early stage of healing, these two processes are independent. Once coverage of the wound is complete, the corium apparently participates toward the restitution and differentiation of the epidermis.

Arterioles, particularly those related to arrector pili muscles, were found to extend to more superficial levels than previously reported. At a certain level, about 214 micra below the epidermis, these arterioles become terminal in character. Injury, thrombosis or embolism at this level results in localized skin necrosis.—GEORGE MIKHAIL, M.D., and NICHOLAS S. GIMBEL, M.D. Presented before the Detroit Surgical Association, January 27, 1964.

Accessory Bile Ducts

Their Significance During Cholecystectomy

Accessory bile ducts were found in 15.2 per cent of 348 extrahepatic biliary duct systems. They emerge from the right lobe of the liver and join either the gall bladder or the main extrahepatic ducts. Accessory bile ducts vary in size from minute channels entering the gall bladder, to larger ducts 1-4 millimeters in diameter joining the major bile ducts. Those entering the gall bladder, cystic and cystohepatic duct junction are of particular surgical significance during cholecystectomy, and have an incidence of 6.6 per cent. The small accessory ducts entering the gall bladder will be divided by necessity during cholecystectomy, however, it is advisable to retain the continuity of the larger accessory ducts joining the cystic and cystohepatic junction due to the segmental origin of accessory ducts within the liver, and to avoid mistaking an accessory duct for an aberrant low union of the right hepatic duct. Inadvertent trauma to an accessory duct may produce postoperative leakage of bile into the subhepatic space.

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THE ACCUMULATION of bile within the peritoneal cavity following cholecystectomy is usually attributed to a sloughed ligature on the cystic duct, or inadvertent trauma to the major bile ducts. This same sequella, however, may follow the division of an accessory bile duct during the excision of the gall bladder and the proximal portion of cystic duct. This can especially occur when inflammatory changes following either acute or chronic cholecystitis obscure the structures about the gall bladder so as to make the identification of even normal ducts and associated arteries difficult. Accessory bile ducts may also be overlooked because of their comparatively small size or unexpected occurrence with subsequent postoperative leakage of bile into the subhepatic and subphrenic spaces.

The incidence of accessory bile ducts has been reported by Lichtenstein[5] as 10 per cent, Flint[1] 15 per cent, Michels[10] 18 per cent, Osler[12] 20 per cent, and Johnston[7] 31 per cent (in 35 specimens).

In the dissection of 348 gall bladders and associated subhepatic bile ducts, including those previously reported by the author,[11] 53 accessory bile ducts were found, an incidence of 15.2 per cent. The pattern, location and junction of these accessory ducts will be reviewed. An accessory bile duct is an aberrant extrahepatic duct entering the major ducts or gall bladder. The term "accessory" is used herein to avoid confusion with an aberrant union or course of the major ducts. The accessory ducts observed, emerged from the liver slightly posterior and to the right of the portal fissure. They descended downward and forward to join the extrahepatic bile ducts and gall bladder. They were located within the peritoneal reflection which enclosed the triangular area between the liver, gall bladder and

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cystic duct, and the common hepatic duct. The junction of these accessory ducts with the extrahepatic biliary duct system is summarized in Table I.

of the latter, differ considerably in length. They join the distal half of the cystic duct, rarely its proximal portion near the gall bladder. The largest of the acces-

TABLE I. ACCESSORY BILE DUCTS

Joined	Number	Per Cent	Range of Size in mm.	
			Diameter	Length
Gallbladder	3	0.9	0.5-1	4- 8
Gallbladder and right hepatic duct	4	1.1	1-1.5	23-37
Cystic duct	7	2.0	1-3	15-35
Cystohepatic duct junction	9	2.6	2-4	24-43
Common hepatic duct (distal half)	11	3.2	1-4	16-38
Common hepatic duct (proximal half)	10	2.9	2-3	12-26
Right hepatic duct	5	1.4	1-3	10-17
Right and common hepatic duct	4	1.1	2-3	15-30
Total	53	15.2		

All percentages=per cent of 348

These accessory ducts usually arose from the right lobe of the liver, occasionally the left lobe, rarely the caudate. They occurred as single accessory ducts, with the exception of those joining the gall bladder which were frequently multiple. As a rule, the smallest and shortest ducts entered the gall bladder, while the largest and longest joined the junction of the cystic and common hepatic bile ducts. They varied significantly in size from minute channels to large ducts 3 to 4 millimeters in diameter. The smaller ones may be mistaken for connective tissue strands or autonomic nerves which are prominent in size in this region, and as such may be overlooked during the exposure and mobilization of the cystic duct and gall bladder. The larger ducts are more readily identified, although coexistent vascular anomalies of the right hepatic and cystic arteries frequently overlay their terminal course.

The accessory ducts which join the gall bladder, cystic duct and cystohepatic junction are of particular surgical significance during cholecystectomy and represent a total incidence of 6.6 per cent (Fig. 1-a). Those which join the gall bladder arise in the adjacent gallbladder fossa of the liver and enter its non-peritonealized surface. These are usually two or more small ducts (a millimeter or less in diameter) and may be mistaken for connective tissue or small veins which commonly accompany them into the liver. Single ducts of slightly larger size enter the gall bladder and communicate with the right hepatic duct. These course along the floor of the gall bladder fossa and have one or more connections with the liver. Mentzer[9] has verified the small ducts entering the gall bladder by microscopic examination of autopsy material.

The accessory ducts which enter the cystic duct are 1 to 3 mm. in diameter, but due to the variable course

sory ducts join superiorly or posteriorly the union of the cystic and common hepatic ducts (the cystohepatic junction). These may be mistaken for a rare low junction of the right and left hepatic ducts, with the cystic joining either one of the ducts to form the common bile duct. Two cases of this low junction of the hepatic ducts were found (Fig. 1-c). (Note the similarity with an accessory duct joining the cystic in Figure 1-b.) As a general rule, the ducts which are definitely smaller than the common hepatic are accessory, while those approaching the size of the common hepatic are likely to be the right hepatic with a low junction with the left hepatic duct.

Accessory ducts which join the terminal half of the common hepatic were found in 3.2 per cent. They are commonly related to the ascending course of the right and aberrant right hepatic arteries which cross or parallel their junction with the right side of the common hepatic duct. These ducts would be encountered during the exposure of the common hepatic duct or during the identification of the cystic artery. Accessory ducts entering the proximal half of the common and right hepatic ducts were found in 5.4 per cent. These are the most variable in pattern of all the accessory ducts and frequently exhibit branching and connections with both of these ducts (Fig. 1-a). The terminal ramifications of the right hepatic artery pass between or around their origins. Fortunately, these are above the usual operative area, and would not be encountered except in hilar exploration of the major bile ducts.

An unusual accessory duct measuring 3 mm. in diameter was found originating from the caudate lobe of the liver. It crossed the portal vein to enter the left side of the common hepatic duct about 1 cm. above the

cystohepatic junction. In another case, an accessory duct from the left lobe of the liver entered the left side of the common hepatic near its origin.

It has often been emphasized that injuries to the major extrahepatic bile ducts and associated arteries occur most frequently during cholecystectomy. The risk of injury should be decreased if there is good exposure of the major ducts in a bloodless field, and if one remembers that variation in the course and pattern of both the ducts and arteries is not uncommon, and that no structure should be clamped or divided until it has been accurately identified.

Accessory ducts, if present, are identified during the mobilization of the gall bladder and cystic duct. Those entering the gall bladder will be, by necessity, divided and ligated to prevent a postoperative leakage of bile. There are, however, two important exceptions to ligating the ducts which enter the gall bladder. Both of these are fortunately very rare, and these ducts are larger than the usual accessory ducts entering the gall bladder. (1) Congenital absence of the common hepatic and common bile ducts; the right and left hepatic ducts enter separately into the terminal end of the gall bladder, and thereby the cystic duct conveys all the bile from the liver into the duodendum (Fig. 1-d). Williams[13] reported such a case found at operation. (2) The right hepatic duct enters the gall bladder, while the left hepatic duct joins the cystic to form the common bile duct (Fig. 1-e).

The large accessory ducts which join the cystic duct or the cystohepatic junction should not be subjected to trauma or ligated during the isolation of the cystic duct. As previously noted, a large duct entering this region may be an aberrant low union of the right hepatic duct. After identification of these ducts, it is recommended that the cystic duct be transected and ligated between the gall bladder and the junction of the accessory or aberrant duct with the cystic duct. Studies by Healey[3,4,5] and others[2,14,15] on the intrahepatic distribution of the blood vessels and bile ducts, indicate that they supply segmental intrahepatic portions of the liver. Goldsmith and Woodburne[2] conclude that the accessory or aberrant ducts do not duplicate the function of the major bile ducts due to their specific segmental origin within the liver. Thus these aberrant ducts are "accessory" to the major extrahepatic bile ducts in location and junction, but are replacing ducts in function. This suggests that those accessory ducts entering the cystic duct, especially the larger ones, should be allowed to retain their continuity with the extrahepatic biliary duct system.

Vascular anomalies related to the major bile ducts

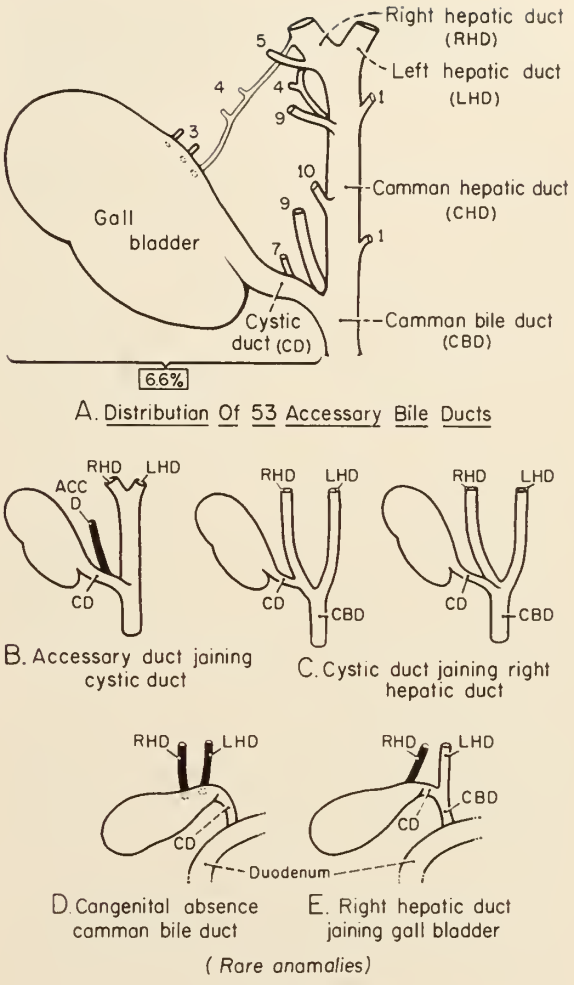


Fig. 1.

encountered during cholecystectomy, are also related to the course of the accessory ducts which join the cystic and cystohepatic junction. Thus a brief comment on the more common of these may be useful. Vascular anomalies occurring within the cholecystohepatic triangle are found in approximately 25 per cent of cases. The most surgically significant is an anomolous course of the right hepatic artery appearing within the operative field during the identification of the major bile ducts and the ligation of the cystic duct and artery. The right hepatic artery not infrequently has a low looping course as it passes from left to right behind the common hepatic duct (it is anterior in 20 per cent), and then courses parallel to the cystic duct. It courses either above, on, or behind the cystic duct, and then after giving rise to the cystic artery, turns upward to reach the liver between the gall bladder and the hilar structures. Since the right hepatic artery supplies about half of the liver, it is important not to

mistake its looping course along the cystic duct for the cystic artery. Thus any artery coursing near the cystic duct, especially if over 2 mm. in diameter, should be traced to the gall-badder wall before concluding it is the cystic artery.

Another anomaly (found in approximately 18 per cent) is an aberrant right hepatic artery (usually derived from the superior mesenteric[11]) which ascends behind the cystic duct to reach the liver above the cystohepatic junction, and is a common source of the cystic artery. Both the right and aberrant right hepatic arteries or their cystic branches in the cholecystohepatic triangle frequently cross or spiral around the accessory bile ducts. Dissection to expose the origin of the cystic artery in these instances may traumatize these ducts. The cystic artery is variable in position, pattern and course, and its origin may be from a more remote source (common or left hepatic, and gastroduodenal arteries[6]). Doubling occurs in 15 per cent. However, regardless of its origin, course or branching, the cystic artery should be identified during cholecystectomy by its termination on the gall bladder. By ligating the cystic artery reasonably close to the gall bladder, and distal to its origin or communications, it is not so likely to be mistaken for another artery, particularly the right, aberrant right, or an anomolous common hepatic which may course through the operative field.

Summary and Conclusions

Accessory bile ducts occur in approximately 15 per cent. Those joining the gall bladder, cystic duct and the cystohepatic junction have a total incidence of 6.6 per cent, and are of particular significance during cholecystectomy.

Accessory bile ducts joining the gall bladder require ligation. An aberrant right or left hepatic duct joining the gall bladder is the exception.

Studies on the intrahepatic origin of the bile ducts indicate that the accessory bile ducts are segmental in origin. This suggests that the continuity of accessory ducts joining the cystic or common hepatic ducts should not be compromised.

An inadvertent injury of an accessory or a major bile duct during cholecystectomy may subsequently produce a subhepatic or subphrenic collection of bile, or a troublesome external biliary fistula.

An appropriate drain placed in the right subhepatic space and brought out through a stab wound lateral to the incision may not always be necessary, but does less harm than an accumulation of bile in the peritoneal cavity following cholecystectomy without drainage.

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To Train More Veterinarians

Michigan State University will educate more veterinarians at less cost per student and in less time than at present through a sweeping revision in curriculum. The new program will extend the present three terms per year to four terms and will admit two classes per year of 50 students each rather than one class of 64.

Revisions will begin in 1964 but will not become fully effective until 1965, reports Willis W. Armistead, dean of veterinary medicine.

The Need for Close Working Relationships Between Hospital Administration And the Medical Staff

Unless hospitals and doctors join hands and resolve the health needs of the community in the best interests of all and at the lowest possible cost, a third party will be dictating for us in a manner that we would not enjoy and which would not be in the best interests of our citizens.

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IN TOO MANY hospitals a figurative fence exists between hospital administration and the medical staff. If the patients in our hospitals are to receive the quality of care to which they are entitled this barrier must be removed.

With the rapid advances in medicine in recent decades and the increasing dependence of the medical profession on the para-medical disciplines, the hospital is increasingly becoming the center for the rendition of health care.

This is true not only for the hospitalized patient but also for the ambulatory patient. As the medical profession is increasingly using and is dependent on the diagnostic aids of the laboratory and radiology, the hospital is frequently the focus of this assistance. The profession is finding that, with the increasing knowledge in all the health fields and with the increasing demand for its services, it can extend itself to serve more patients more effectively with the assistance of the para-medical disciplines such as the dietitian, the physical therapist, the occupational therapist, and the professional social worker. The focus of these disciplines is also most often in the hospital.

It is my prediction that as the years pass the hospital will increasingly become the center from which health care will be rendered. Today various home care programs exist to meet the health needs of society more effectively and at a lower cost than has been previously possible. These involve not only the doctor but the nurse, the physical therapist, the dietitian and the occupational therapist. Many of these radiate from a hospital base. There is a beginning trend for "professional" buildings providing physicians' offices located adjacent to and not infrequently directly connected to hospitals, thus enabling the physician to practice more efficiently.

We see an ever increasing trend on the part of the public to go to hospital Emergency Rooms or Services to meet their emergent medical needs. Hospitals have sometimes been criticized for this trend and also charged with trying to take over the practice of medicine. Hospitals can not practice medicine; that can only be done by physicians. The trend has developed for two main reasons. The public has become convinced that the full spectrum of their emergent needs can be more readily met in the hospital environment than in their home or the usual physician's office. Secondly, physicians, individually and collectively, have not always kept their services readily available to meet these emergent needs. The public has found that through the hospital they more readily obtain what they believe are needed services. This being the situation then it behooves the medical staff and hospital administration to work out the necessary arrangements to provide adequate and immediately available medical

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Read at the Conference of Hospital Administrators and Chiefs of Medical Staffs, Wisconsin Hospital Association and Wisconsin State Medical Society, Madison, Wisconsin, February 21 and 22, 1963.

Doctor Nelson is Associate Director, University Hospital, University of Michigan.

services in the Emergency Room. Strife over this point leads only to destruction of the image of the physician and the hospital.

Having looked at some of the trends that emphasize the need for a close working relationship let us look at the situation as it is today and see what other factors there are behind this need. First and foremost is the patient for whom both the physician and the hospital administrator exist and without whom there would be need for neither one. Without a close working relationship it is impossible to meet the needs of the patient at the desirable level of quality. Unless the hospital administrator listens to the needs of the physicians for equipment, supplies, and the staff required to render the high level care, the physician must compromise his program of care or perhaps expose his patient to risks that are unnecessary. On the other side the physician must carefully evaluate his requirements to be certain that they are a necessity for care, not a luxury or a slight variation of something already available which is equally capable of meeting the same need. The administrator must understand that the vast majority of physicians are dedicated and do not make demands unless they are really convinced of their value to patient care. There must also be understanding by the medical staff that the majority of hospital administrators are equally dedicated to this principle but often the scarcity of funds precludes acceding to valid requests. This situation may not necessarily be of the administrator's making but that of the Board of Trustees or Directors who have a misconceived concept of the economy of hospital operation. Herein the Medical Staff can be of real assistance to the administrators by instilling in the Board the philosophy of meeting patients' needs while still seeking economy of operation.

This rising cost of health care is of equal concern to both physician and hospital administration. A close working relationship between the two has the potential of some real impact on the problem. Careful evaluation of equipment needs I have mentioned. Agreement to standardization of supplies is second.

Reduction in the variety of surgical dressings and the substitution of lower cost dressings for the more expensive ones is another example. Economy in the use of supplies should be instilled in every physician's mind.

The pharmacy is another area where a close working relationship between administrator and staff can effect real economies. The number of brands of a generic drug can vary from two to seven or more. If the medical staff can agree on the use of medications by generic name rather than each insisting on his pet brand the varieties of drugs carried in the pharmacy can be markedly reduced. Quantities of each kind are then increased. Purchasing done on this basis, with competitive bidding, can produce the same high quality drugs at marked savings in cost.

While these savings may seem a trivial part in today's high level of cost, every contribution helps hold the line in the continuing rise.

Of course, the biggest element, 65 to 70 per cent in fact, in hospital cost is personnel. Here, too, a close working relationship can contribute to good quality of care at a lower cost. Analysis of the demands by the staff in the kinds of services required, the scheduling of these services and the kind of service performed by a given class of personnel may enable hospital administration to employ fewer personnel or to substitute a lower cost person, thereby effecting an economy.

This requires a contribution of effort on the part of the medical staff. Because of medical staff insistence duties are often carried on by registered nurses, when they could be performed equally well by an aide or a clerk trained to do the job. Nurses are not only in short supply but they are also relatively expensive personnel. Even so, they are not being paid enough for the skills they possess. Recently I visited a hospital where on a 50-bed patient unit it was taking the full time of two registered nurses to transcribe phycians' orders for laboratory and x-ray procedures to the appropriate requisition forms. Intelligent, trained clerks could have performed this function equally well I am sure—and at a considerably lower cost. Why this practice continued this way I did not ascertain, but certainly if hospital administration did not act to change, a medical staff conscious of patient costs could have suggested the possibility.

On the other side of the coin, hospital administrators must be willing to listen to the need to introduce a new kind of personnel to the organization so that modern medical knowledge and practice may be carried out. Both parties must be willing to look at tradition and be willing to make changes in light of today's health care evolution.

There is another and more difficult area which requires attention if we are to meet the high cost problem. This occurs in communities with more than one hospital or communities with another hospital in a relatively near-by community. This is the duplication of equipment and even bed space when there is unused capacity in existing facilities. Here we have local pride as well as convenience as a matter of concern. Boards, hospital administrators and medical staffs are equally involved. When hospital A in community X installs,

for example, a cobalt unit which is adequate to meet the total needs of the community, there is a tendency for hospital B in the same community to also move in this direction. Such duplication of unneeded equipment or beds or other facility is a real factor in increasing costs. The solution requires not just a close working relationship within the given hospital but also between hospitals.

Another area of need for close relationships between hospital administration and medical staff is the responsibility of the Board of Trustees or Directors in the appointment of the medical staff, the maintenance of standards of care and staff discipline. The courts have ruled that these are legal responsibilities of the Board. The hospital administrator is the executive officer of the Board. As such he is responsible for carrying out the policies of the Board, executing its decisions and acting as liaison in most instances between the Board and Medical Staff. In this latter responsibility he is sometimes assisted by a Joint Conference Committee composed of Board Members and Medical Staff representatives. Since Board members are usually laymen, they must rely on the judgment and advice of the medical staff. Since the majority of hospital administrators are laymen, they must be dependent on the medical staff in carrying out their duties. There is real need for close relationships if the Board is to discharge its responsibilities, the administrator his duties and the medical staff to be properly selected and its standard of performance maintained.

This is one of the most delicate areas in which the administrator has to perform. A close relationship with the Chief of Staff, in particular in these matters, can be of immeasurable aid to him. A close relationship with the executive committee of the medical staff is the next most important asset to him. Frequent and regularly scheduled conferences with the Chief of Staff should be held. In these each can bring up and discuss in an informal atmosphere problems or potential problems that are apparent or suspected by each. If agreement is reached that a problem exists, then a program of action can be outlined for its resolution, hopefully in a manner that will be least traumatic to any or all parties concerned: the hospital, the board, the administrator, the medical staff and the individual or individuals involved.

This area of need places a real responsibility on the shoulders of the Chief of Staff. This is not an honorary position. It is not an easy position to hold. Effective performance in this position demands that the individual give of his time, that he will listen with an open mind and that he will be as objective in his conclusions as is humanly possible. If this performance is attained and a close relationship with the administrator is obtained, then the patients in the hospital can be assured of the highest level of care that is obtainable.

Earlier I have referred to the need for understanding by both the administrator and the medical staff in order to achieve a close working relationship. This can only be achieved by free communication by both parties. The administrator's door should be open to the medical staff at all times. The administrator should be the "number one promoter" of effective functioning of the Joint Conference Committee. The Medical Staff should welcome the administrator to its committee meetings and staff meetings. In the latter the administrator should have a standing item on the agenda to make a report to the staff on administrative activities, problems and programs. Certainly in planning any new facility for patients, medical staff should participate. This is equally true of the other hospital disciplines that will function in the addition. Only with free exchange of information can understanding be achieved and the needs of the patients met in the best possible way.

Summary

There is need for close working relationships between hospital administration and medical staff if the Board of Trustees, the administration and the medical staff are to discharge their legal and moral responsibilities in the interest of the highest quality of patient care. Unless hospitals and doctors join hands and resolve the health needs of the community—be it local, state or national—in the best interests of all and at the lowest possible cost, a third party will be dictating them for us in a manner that we would not enjoy, and which would not be in the best interests of our citizens.

Standards For a Blood Transfusion Service

E. E. Muirhead, M.D.
Detroit, Michigan

E. R. Jennings, M.D.
Long Beach, California

THE FOURTH edition of "Standards for a Blood Transfusion Service," prepared by the Committee on Standards of the American Association of Blood Banks (AABB), was published in November, 1963. It is proper for physicians in Medicine to reflect on the general meaning of this document and its potential relationship to the care of patients. In this respect, we should like to consider, at this time, the background, guiding principles and purposes of the Standards, as well as certain of its contents.

Background

The publication of the Standards for a Blood Transfusion Service was the result of extensive work, performed by several committees which met many times over a period of years. The members of these committees, by their training, professional experience and personal interests, were very well qualified to perform the task of composing the Standards. Collectively, those directly involved in the evolution of this document represented a pool of knowledge and experience in the field of blood transfusions which would be difficult to excel. By their varied positions in large community blood banks and hospital transfusion services and by their length of service in the field of blood banking and transfusions, they possessed a vantage point which allowed close contact with all aspects of blood, from the selection of donors, the processing and storage of blood to the giving of blood and its derivatives and the investigation of untoward reactions, when these occur. Thus, the authors and their publication differed in many respects from those of other standards, previously published. Other documents along related lines, effective and commendable as they have been, nevertheless have been prepared in the main by governmental agencies concerned primarily with the attainment of a safe, biologic product and not so much interested in techniques and procedures related to the usage of blood and its derivatives. Blood banking, when all is said, is the practice of medicine and in its ultimate analysis constitutes a service to patients and not just the preparation of a product. The Standards of the AABB were developed with the concept of service as a basic feature.

In 1956, two agencies, the American Association of Blood Banks and the Joint Blood Council, whose interests dealt mainly with blood transfusion services, pooled their efforts in preparing the first edition of the Standards. The first three editions of the document resulted from this joint effort. When the Joint Blood Council dissolved its corporate structure, the need for a revision of the Standards was already evident; the Committee on Standards of the AABB prepared the fourth edition, the present document.

The Committee on Standards was so constituted as to have members from all sections of the country. This arrangement was purposeful. Certain aspects of blood transfusion practices may be properly conducted by alternative, yet effective, approaches and some approaches may result from a local habit pattern. Having authors from various sections of the country avoided the interjection of provincialism while, at the same time, making the document representative of the thinking of a cross-section of the nation with respect to blood transfusion practices.

Guiding Principles

The Standards are minimal standards, by which is meant that adherence to its guidance in blood transfusion practices will give rise to a modern and effective

From the Blood Bank, Woman's Hospital, Department of Pathology, Wayne State University, School of Medicine, Detroit, Michigan, and Department of Pathology, The Memorial Hospital of Long Beach, Long Beach, California.

blood transfusion service. In general, they are not meant to be restrictive. Any given transfusion service may wish to become more stringent in its practices, such as by performing additional acceptable and established procedures beyond those stipulated by the document in checking the grouping and compatibility of blood. Such additions are, naturally, a matter for local option. The basic tenet of the Standards is to serve as a guideline below which no service should fall. Thus, any blood transfusion service which will use the Standards as a basis for operation is considered as one practicing this phase of medicine in an effective, up-to-date and generally acceptable fashion.

Restriction has been interjected into the document only when considered necessary in achieving the desired results. The main pitfall which the group attempted to avoid was that of requiring transfusion services to adhere to rigid standards which could not be justified on the basis of wide experience. As in other branches of medicine, there generally were alternative ways to accomplish the same desired results. However, when the authors felt that a wide latitude appeared inimical to the main aims, namely the safety of the transfusion for the donor and the recipient, the section involved was written in such a way as to insure adherence to an established technique. A good example of this type concerns compatibility testing between donor and recipient. It was necessary to listen freely and openly to various competent workers regarding the concepts of adequate compatibility. The alternative approaches ultimately agreed upon included specific and restrictive techniques.

Contents

The Standards begins by specifying that "the selection of donors, the collection, storage, processing and transfusion of blood shall be the responsibility of a *qualified, licensed physician*" completely knowledgeable in transfusion principles and practice. It insists on adequate staffs, quarters and equipment.

Then the Standards considers all aspects of the donor and the recipient. This is followed by standards dealing with the preparation of blood components, such as packed red cells and plasma. A new section deals with the use of plasmapheresis, a technique which shows great promise in special circumstances. Types of transfusion reactions and their investigation represent still another section. Finally, the document concludes with a consideration of records related to a transfusion service.

The inclusive nature of the Standards makes it a worthwhile reference for physicians who utilize blood and its derivatives in the management of their patients.

Purposes

The Standards were written with several purposes in mind. Judging from prior editions, it would seem that the document has filled a definite need. Certainly, no standards for a blood transfusion service has gained the wide utilization afforded this particular document by workers in the field of transfusions. Plans for translations into several foreign languages are in progress. The purposes may be reviewed under three headings:

1. *Protection of Donors, Patients, Doctors, Community Blood Banks and Hospitals.*—The Standards, as stated above, are guidelines of good practice, and through this means are of benefit to the donor and the patient who receives the blood. Adherence to these standards provides a level of safety which is a source of confidence both donor and patient may enjoy. The doctor who orders the transfusion and the physician responsible for the transfusion service similarly gain protection by adhering to established principles which are clearly enunciated and which can be utilized in case of medico-legal action.

The physician who is accused of malpractice because of an unavoidable untoward reaction, for example serum hepatitis, may point to the Standards with confidence for his defense. In the document it is clearly stated, as an authoritative consensus of opinion, that "the possible presence of the agent of viral hepatitis in donors cannot be eliminated by history, physical examination, laboratory test, or by any other means available today." Similarly, the hospital and community blood bank may refer to the Standards when attempting to defend themselves concerning the manner of their practice.

2. *Source of Information.*—The Standards represent the thinking of a large group of individuals who are expert in the field of transfusions; consequently, they certainly are an authoritative source of information. This information is particularly useful to the director of a transfusion service who is attempting to change procedures in his service in order to conform with modern concepts of safety and performance. They are useful in the instruction of physicians whose practice may not be in keeping with modern views on transfusion therapy. For instance, the addition of any medication to the blood prior to or during a transfusion (except for A and B substances) is not condoned. It

can be indicated that such requests cannot be honored without violation of reliable recommendations as embodied in the Standards.

3. *Basis of the Inspection and Accreditation Program of the AABB.*—The AABB has developed a successful voluntary inspection and accreditation program for blood banks. As with similar programs of other medical disciplines, the inspection is designed to serve as a consultative episode, one destined to aid and assist blood banks in improving their services to patients. Such an inspection and accreditation program must be based upon a sound set of standards of practice. The AABB Standards has served this purpose well.

In this special application, the Standards has reached its highest effectiveness thus far. While improving the practice of blood banking through this means, those concerned, at the same time, have learned of deficiencies in its makeup and have made provisions for improving these.

Conclusion

The introductory remarks of the Standards as sponsored by the AABB state that "these standards . . . have been prepared for the purpose of improving the quality and safety of human blood transfusions." The above discussion has attempted to indicate, in a general way, how the Standards were developed and applied for these purposes.

The present document, naturally, does not constitute an ultimate answer. This cannot be, since the practice of blood transfusions is continually changing and the standards must adapt to these changes. It certainly represents a better set of standards than that of former editions. Moreover, sections have been written for new areas of practice, such as plasmapheresis, and it is expected that other sections will be added as their need becomes apparent.

The document is helpful, not restrictive, and a definitive aid in providing safe and effective blood transfusions.

Tracheostomy and Ventilators

A program of airway management is described, and causes of respiratory insufficiency are given. In the Thoracic Surgery Division at Henry Ford Hospital, the indications for tracheostomy are: medical, such as in myasthenia gravis, following trauma of the neck, and postoperatively in patients with respiratory distress. The causes of postoperative hypoxia are: hypoventilation, low cardiac output and defects in oxygen diffusion. A technic of tracheostomy and its management is described. Strict sterility is stressed.

With the help of blood-gas determinations, a decision can be made whether to use ventilatory assistance or not. The three causes of postoperative hypoxia are illustrated with typical cases. The importance of tracheostomy and ventilatory assistance is demonstrated.

In conclusion, the treatment of pulmonary insufficiency is (1) adequate control of the airway, (2) assisted ventilation, and (3) measurements of blood-gases.—Jean P. van de Kerckhof, M.D., and Rodman E. Taber, M.D. Presented before the Detroit Surgical Association, March 23, 1964.

Teaching and Learning With Other Lands

The Institute of International Education has released interesting figures from "Open Doors 1963," an annual survey conducted by that organization.

In 1962-63, there were 64,705 foreign students in 1,805 institutions in the United States. They came from 152 countries and their number increased by more than 6,000 over the 1961-62 enrollment.

* * *

SEVEN THOUSAND OF these students were from Canada, 6,000 from India, 5,500 from the Republic of China, almost 3,000 from Japan and Iran, over 2,000 from Korea and from the Philippines, and well over 1,000 each from Hong Kong, Cuba, Greece, and the United Kingdom.

Forty-five per cent of all foreign students are to be found in the states of California, New York, Illinois, Michigan and Massachusetts, with Michigan ranking fourth and providing an education for 3,904 foreign students. The University of Michigan alone had 1,325 such students and was only surpassed in number by the University of California, New York University, and the University of Illinois. Shortly behind Michigan in numbers were Columbia University, the University of Minnesota, the University of Wisconsin, Harvard, and the University of Southern California. Forty-five per cent of the foreign students were in graduate school and 7 per cent were students in the medical sciences. The largest number, totaling 22 per cent, were registered in engineering.

Over 26,000 of the foreign students were self-supporting, while 11,000 were supported by United States institutions, 7,000 by private organizations, 5,000 by the United States government, and over 3,000 by foreign governments. The balance were supported by a variety of sources, including combination of institutional, government, and private organization assistance.

By contrast, the United States the previous year had only 16,000 students abroad, studying at 411 institutions in 60 foreign countries. Canada was the favorite location for these students with 2,500, and France was close behind

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with 2,000, followed by Mexico with 1,600 and it is interesting to note that 1,500 of those were enrolled at Mexico City College. The University of Paris with 980 was second, followed closely by the Pontifical Gregorian University at Vatican City with 942. Of interest to physicians is to note that 320 Americans studied that year at the American Medical Society of Vienna, Postgraduate Medical School of the University of Vienna.

Additional information of interest is that pertaining to foreign scholars in American institutions in 1962-63. Foreign scholars are faculty members and there were 5,830 such scholars representing 90 countries. Japan, the United Kingdom, India, Germany, and the Republic of China were the leading countries.

* * *

THE LARGEST number of foreign scholars were in the field of natural and physical sciences, totaling 2,500, but the medical sciences were second at 1,080. Sixteen United States institutions reported 100 or more foreign scholars. The University of California had 509, Massachusetts Institute of Technology had 317, Harvard 302, Minnesota 167, and The University of Michigan 155.

* * *

AT THE SAME TIME, there were 2,907 United States faculty members in 101 foreign countries. These faculty members taught or conducted research and 49 per cent of them spent their time in Europe, 14 per cent in the Far East, 11 per cent in Latin America, 9 per cent in the Near and Middle East, and 8 per cent in Africa. Michigan State University had the largest number of faculty members abroad at 196, while The University of California was second with 149, and The University of Michigan third with 88. Only 4.8 per cent of American faculty members abroad were in the medical sciences.

It would appear that the United States is making an important effort to provide educational facilities for students from other lands and that the State of Michigan is doing its share, and more, to support this effort.

Help and Where to Find It

By Occupational Health Committee
Michigan State Medical Society

Each generation of physicians, from the 17th century to the present, has heard Ramazzini's admonition to inquire of each patient, "Of what trade are you?"

This is but the first of many steps in attempting to evaluate the possible relationship between the patient's illness and his work environment. As the types of jobs have multiplied and as industry and agriculture have adopted the advances of a rapidly changing technology, it has become increasingly difficult for the practitioner to be familiar with the nature of his patient's work.

A careful occupational history will include the patient's description of his jobs, past and present. Such information is invaluable, but the wise physician will recognize that the patient frequently does not know the nature of the materials with which he works, nor their influence or lack of influence on his health. If the clinical circumstances are such as to suggest that environmental factors may be contributing to the disease process, the physician needs reliable and properly interpreted information regarding that environment.

Information of the type required may be readily available. In some circumstances, elaborate investigation by other scientists may be required. While there are no single roads to be followed, the following guideposts may prove helpful. Knowledge gained from textbooks in Occupational Medicine or Industrial Hygiene may provide an immediate clue whether further investigation is indicated. If the plant where the patient works has a medical department, as many of our Michigan industries do, details of the patient's job and his exposure may be obtained from the plant physician. In the absence of a medical department, such information may frequently be obtained from the plant management.

The Division of Occupational Health of the Michigan Department of Health, 3500 North

Logan Street, Lansing 4, Michigan, has accurate information on environmental conditions in plants throughout the state. This information is frequently supported by air and other analyses performed within the plant by health department personnel. The pertinent material is made available to the physician in clearly interpreted form.

Within the City of Detroit, similar information may be obtained from the Bureau of Industrial Hygiene, Detroit Department of Health, 8801 John C. Lodge Expressway, Detroit 2.

In his medical work-up of the patient, the physician is well aware of the importance of objective findings and tests in documenting the patient's illness. It is equally important that environmental analysis not rest on hear-say.

Michigan Week Is Good Medicine

Michigan IS great in resources and opportunity

As the 11th Annual Michigan Week (May 17-23) approaches, we shall be exposed to much promotional material about the magnetism of Michigan. We will hear about Michigan Day at the New York World's Fair. Over and over reports will pour in about awards given for community achievement and agricultural development. The order of the day will be open houses, the exchange of mayors, parades, exhibits, ad infinitum.

This is well and good. The people of Michigan are bragging about their state and they have something good to brag about. And with every brag the stock of Michigan is pushed a little bit higher for not only does the recipient of the effort get a little more knowledge about this state but the person doing the bragging sells Michigan to himself as well.

Up to a few years ago the professional people of this state left the promotion up to the business people and the pros they hired. But that's changing. The professional people of Michigan have more to brag about than any other segment of society, and the medical profession with its myriad accomplishments stands at the head of the list.

Editorial Comment

Vigilance

Kalamazoo Academy of Medicine *Bulletin*,
Vol. 54, No. 3

The Government (us) intends to force the Taxpayers (us) to kick in to provide medical care for the People (us). The program would be compulsory; it would be nationally controlled; it would apply to all, regardless of need. It would be paid for out of taxes, not out of contributions. And it would assure only limited medical care.

How many would take out the "insurance" policy if the agent said, "You are to give me a part of every pay check. Since we don't know the cost of the benefits, the amount you pay in future years will be determined later. However, it will be compulsory, once you start. The policy won't have any cash value, and it won't help you until you are 65. Even then your money won't help you because it will have been spent; however, the money we get from selling policies to the next generation will pay part of your hospital bills. That is, if you have the care in certain hospitals and agree to have a physician who is on the staff of the hospital. And just think, the whole program will be government controlled?"

A government health plan would destroy the American concept of individual and family responsibility. It is contrary to the American tradition of independence and self-reliance. Nikita Khrushchev is reported to have said, "We cannot expect the Americans to jump from capitalism to communism, but we can assist their elected leaders in giving Americans small doses of socialism, until they suddenly awaken to find they have communism."

A final thought: a government health plan can be proposed time and again. It only has to win once. We have to lose, but once.

—Excerpts from article by
Raymond Pinkham, M.D.

MSMS Centennial Series—1938

Doctor Placement Service Inaugurated

By William J. Stapleton, Jr., M.D.
Detroit, Michigan
MSMS Historian

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number and will continue through August, 1965.*

The President of the Michigan State Medical Society for 1937-38 was Henry Cook, M.D., of Flint.

The total membership was up to 3,963, for a gain of 238.

Looking over the notes regarding the activities of the Society, it strikes me that we, the members, do not realize the tremendous amount of time, energy and their own money that the officers of our Society contributed to the successful making of a growing society like the Michigan State Medical Society. The Executive Committee that year held five meetings. Here is the digest of the March 31 meeting of the Executive Committee in Detroit:

1. Governor Murphy offered to help the MSMS in the work of the AMA Survey. (Survey to ascertain the adequacy of medical care.)

2. Right of employes of state penal institutions to choose their doctors was demanded.

3. Request was made for amplification of Attorney General's opinion re interpretation of x-ray plates.

4. The filter system was made official by the Michigan Crippled Children Commission.



The Author
WILLIAM J.
STAPLETON, JR., M.D.
MSMS Historian

HERE IS A RESUME of the Mid-Winter meeting of The Council in Detroit on January 12 and 13.

1. The Annual Meeting of the MSMS was set for Detroit, September 20-22, to feature 30 guest speakers.

2. The principle of the Michigan Health League's Constitution was approved.



Henry Cook, M.D.
MSMS President
1937-1938

3. All County Medical Societies were urged to continue their filter systems.

4. Report of Committee on Postgraduate Education —The attendance at the intensive intramural courses (Ann Arbor and Detroit) was 354; at extramural courses, 1,107 physicians attended. One hundred twenty-eight doctors attended the courses given in the Upper Peninsula and in the upper portion of the lower peninsula. This made a total of 1,589 doctors attending postgraduate courses this year.

The Executive Committee in Lansing on April 14 authorized MSMS President Henry Cook and MSMS Treasurer William A. Hyland to outline to a committee of the U. S. House of Representatives the place of the private medical practitioner in syphilis control work.

The Executive Committee of The Council met in Eloise on May 19. The following is a digest.

1. Group hospitalization was discussed with trustees of the Michigan Hospital Association.

2. Letter to the MSMS membership re Supreme Court Amendment was given approval.

3. Personnel of the Basic Science Board, as appointed by Governor, was announced.

4. Consolidation of Delta and Schoolcraft County Medical Societies was recommended to the House of Delegates.

5. Elimination of the 13th Councilor District was recommended to the MSMS House of Delegates.

The Executive Committee of The Council met in Washtenaw County, June 30. The following is a digest.

1. Spot Speaker Service was established as an activity of the MSMS.

2. Certificates of "Associate Fellowship in Postgraduate Medical Education, MSMS" were approved to be awarded to approximately 400 physicians at the 1938 annual meeting.

3. MSMS accepted an invitation of the Michigan Crippled Children Commission to write a booklet about "burns."

The Executive Committee met also November 10 and December 13. The following are the highlights:

1. Placement service was created to aid localities in need of a doctor of medicine, to aid physicians in their search of a good location.

2. Occupational Disease Law was discussed with the Commissioner of the Department of Labor and Industry.

3. Syphilis Control Program of Ingham County Medical Society was approved.

Among the important matters of the year was the 73rd Annual Meeting of the Society in Detroit. A new "Conference for Interns and Residents" and the Symposium on the "Business Side of Medicine" were held. There was a total of 76 exhibits shown. The registrations were as follows: Woman's Auxiliary—121; the MSMS—2,007.

* * *

THE WOMAN'S AUXILIARY began the year with 13 Auxiliaries and three new units were formed at Lapeer, Fremont and Washtenaw.

The Joint Committee's activities, its objectives, and particularly its setup within the Extension Department of the University of Michigan and yet not controlled or influenced by the University, has been attracting more and more interest. The MSMS was the originator of the plan and it continues to be one of the most important affiliates of the group. The prime objective of the Committee is to present to the public the fundamental facts of modern scientific medicine.

* * *

MSMS INAUGURATED a placement service, designed to help any community which felt the need of a doctor of medicine, and also to assist young physicians about to enter practice, or older doctors, to find a good location. A survey was undertaken to ascertain the need for additional medical service anywhere in the state.

The MSMS House of Delegates took the following action:

1. The Delta County Medical Society and the Schoolcraft County Medical Society were merged into one medical society known as the Delta-Schoolcraft County Medical Society.

2. The following Councilor Districts were reorganized: 9th, 10th, 12th, and 13th. District 17 was abolished.

* * *

THE APRIL JOURNAL carried an effective story about the benefits of membership. The following benefits were stressed:

1. Assurance of a high ethical standing for you in the community, the state, and the nation, before the public, the law, and the profession.

2. Lectures and postgraduate courses to keep you in touch with medical progress.

3. Your common interests safeguard through the vigilant work of democratically elected officers.

4. Benefits accruing from the actions of numerous committees.

5. Maintenance and constant improvement of standards of medical practice for the protection of patients.

6. A monthly Journal of high quality with the latest scientific information.

The Annual Beaumont Lectures in conjunction with the Wayne County Medical Society was planned for February 20 and 21, 1939, with Jesse Bullaw, M.D., of New York, as the lecturer.

The Alumni Association of the Wayne University College of Medicine held its 49th annual reunion and the Detroit clinics on June 15-16, 1938.

* * *

THE UPPER PENINSULA Medical Society held a conference on August 18 and 19, in Sault Ste. Marie with clinics about Vascular Disease, Back Pain, Nephritis, Management of Gall Bladder Disease.

In closing this article, I salute all the officers, the members of the House of Delegates, the Chairmen of the various Committees, and their respective members for their unselfish work in making the Michigan State Medical Society the successful organization it is.

MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Type E Botulinus Antitoxin

The need in the United States for an immediately available stock of Type E botulinus antitoxin has been emphasized by the occurrence during the past year of three outbreaks of Type E botulism, involving 22 cases. This has been an extraordinary occurrence and contrasts sharply with the experience of the past 30 years during which less than 40 cases in all have been recorded. We have no cause to believe that the experience of 1963 will be repeated in the future. However, since Type E antitoxin is not produced in the United States and thus is not readily available, the Communicable Disease Center, United States Public Health Service, Atlanta, Georgia, has procured a limited supply of Danish polyvalent botulinus antitoxin which includes Type E. This has been titered and tested and will be made available on an emergency basis should the need arise.

Around-the-clock telephone coverage has been established at the Communicable Disease Center. The telephone is: Area Code 404-634-2561.

For Types A and B antitoxin, contact should be made with Lederle Laboratory representatives. They have supplied the following numbers which, similarly, are covered on a twenty-four hours per day basis.

Chicago, Illinois: J. W. Simons, Area Code 312, Telephone CO 7-6400.

Pearl River, N. Y.: H. L. Miran, Area Code 914, Telephone Pearl River 5-5000.

Although time does not permit laboratory studies prior to treatment to determine the botulism type involved, it should be noted that Type E botulism has been associated with fish or fish products such as smoked fish, canned tuna, salmon eggs, etc. Types A and B botulism may be transmitted through a broad spectrum of improperly processed foods including fish and fish products. Thus, unless some form of fish is suspect as the vehicle, treatment with bivalent A and B antitoxin should provide optimum specific therapy.

New Forms for Specimen Containers

The Division of Laboratories has issued new forms for the requisitioning of specimen container supplies. Form F-389 lists all the containers available for submission of serologic, microbiologic, and virologic specimens while form F-390 is concerned with containers for sanitary bacteriology and chemistry.

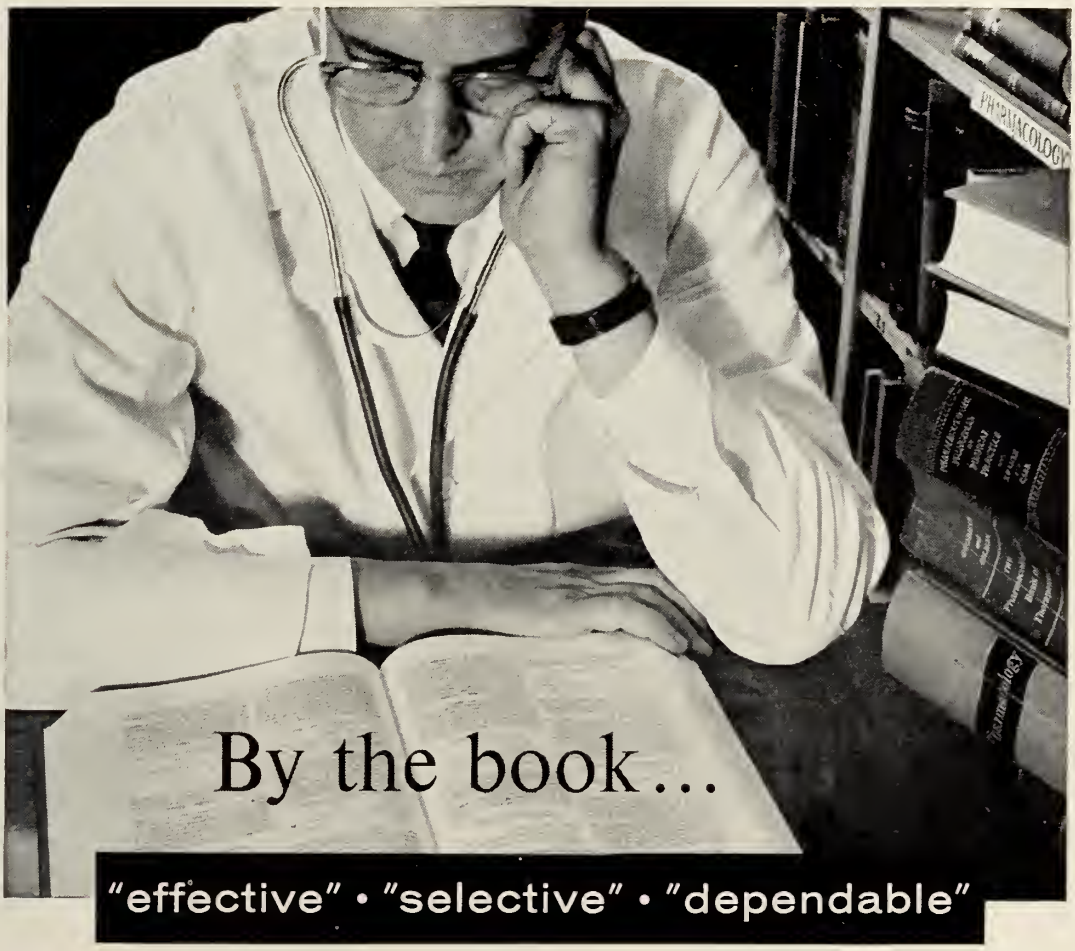
The requisition forms are distributed from the central and branch laboratories with each container order. A space is provided on the requisitions for reordering new supplies of requisition forms.

All physicians who submit specimens to the Division of Laboratories are requested to use the new forms when asking for supplies of specimen shipping containers.

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Opinion Presented On Staff Privileges



Dear Doctor:

I am assuming that your hospital is a private hospital and that its by-laws commit the matter of staff selection and tenure to its Board of Trustees or other governing body. It is my opinion that in such cases the matter of granting or withholding staff privileges is entirely within the good faith and discretion of the governing body.

It is my opinion that the governing body of a private hospital has the right to grant or withhold staff privileges to or from any physician, be he Osteopath or M.D., on the basis of qualifications and/or of meeting the standards set by the hospital so long as it acts, in such matters, in good faith. It therefore follows that the granting of staff privileges to one osteopath would not require that all others be granted similar privileges regardless of qualifications or hospital standards.

I believe the same considerations apply to the limitation of staff privileges to those who are not qualified for full privileges and to the dismissal from the staff of those who fail to meet the hospital standards.

Perhaps the main point to be kept in mind in the matter of granting, withholding, limiting or withdrawing staff privileges, in that to be legally safe that any such action be in good faith and based upon an appraisal of qualifications and of meeting hospital standards rather than on any arbitrary basis of personal prejudice.

Should there be any specific question unanswered by the foregoing, I shall be happy to write you further.

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Seated at the speakers' table are, left to right, John W. Paynter, Chairman, Board of Trustees, Michigan Blue Cross; Sidney Adler, M.D., President, Michigan Blue Shield; Durward Varner, Chancellor, Oakland University; Raymond Perring, President, The Detroit Bank & Trust Company; Miss Emily Pester, Ypsilanti; Robin Buerki, M.D., Executive Director, Henry Ford Hospital, Detroit; Robert Novy, M.D., Detroit; John Mannix, Executive Vice President, Blue Cross of Northeast Ohio, Cleveland.

Blue Shield, Blue Cross Hold 25th Anniversary

How the Blue Shield health care program started twenty-five years ago with a $10,000 advance from the Michigan State Medical Society was recalled by Robert Novy, M.D., of Detroit, at the Blue Cross-Blue Shield twenty-fifth anniversary luncheon March 26, at Cobo Hall.

Dr. Novy declared, "We knew what we wanted and what the people needed, but there wasn't enough money coming in to pay the office rent.

"For many months Blue Shield was forced to withhold twenty per cent of the doctors' fees just to keep the Plan going.

"But when Ford Motor Company came through with its contract, Blue Shield was on its way. The Michigan plan was the first in the nation with one and two million subscribers and we vied with New York for the three millionth subscriber."

Dr. Novy paid tribute to other Michigan physicians who were pioneers in the program, including Doctors Ralph Pino, A. H. Whittaker, Philip Riley and William H. Huron.

* * *

Set Coller-Penberthy Conference, July 30-31

The Thirty-Fifth Annual Coller-Penberthy Medical Conference will be held in Traverse City at the Park Place Motor Inn formerly the Park Place Hotel, July 30 and 31.

As in the past, the Thursday program will consist in short papers of general interest by guest essayists, with an evening cocktail hour



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and banquet with a distinguished speaker, to which the ladies are invited. Friday morning, the professional program will continue, with the afternoon being devoted to recreational activities as the guests may wish, including a golf tournament.

Medical Assistants Conduct Annual Educational Seminar

The theme, "It's A Woman's World," brought 194 members of the Michigan State Medical Assistants Society to Detroit on March 11 for the Seventh Annual Educational Seminar at the Statler-Hilton Hotel.

The L. Fernald Foster Memorial Lecture was presented by Helen Nutting, M.D., a Detroit pediatrician, who told of her work in "This Is My Life."



HELEN MARIE NUTTING, M.D.

Patricia H. Breen, a stock broker in the office of Merrill Lynch, Pierce, Fenner and Smith, in Detroit, told about "Women in Wall Street." Although there are not many women on the floor of the stock exchange, there is an increasing place for women, she said, in the stock market today.

Following the "no-calorie" luncheon, Glenn Millard, M.D., Detroit, presented several members with certificates on completion of the In-Service Training Program. Brief greetings were given by Orlen J. Johnson, M.D., President of the Michigan State Medical Society, and by Hugh Brenneman, MSMS executive director.

Viola Brekke, M.D., pathologist, Highland Park General Hospital, the afternoon speaker, stressed the need for more trained personnel in the fields of medical technology. Dr. Brekke asserted that it is a woman's world, with every opportunity for education and training in any field. She closed with a quotation by Doctor Hastings, a professor at Harvard University, "It is the effort made by each of us in his or her own particular way to apply what he knows, however modest, to mend the ills of others."



VIOLA G. BREKKE, M.D.

Co-chairmen for this Seminar were Misses Gwen Whitcomb and Louise Rutila of Detroit.

MSMS produces many films, TV and radio broadcasts, pamphlets, brochures, and other educational, informational materials.

Say you saw it in the Journal of the Michigan State Medical Society

MAP Favors Single Registration Agency

The Michigan Association of the Professions has taken a stand favoring a single state department for professional registration.

The MAP Congress adopted a resolution which "urges the Legislature, insofar as the Legislature has jurisdiction for such licensing, to establish a single department of professional registration and vocational licensing, and that within such a department there be established two divisions, one for professional registration, the other for vocational licensing, and providing for demarcation between these two occupational entities."

U-M Grads Select 12 Cities For Hospital Internships

Members of the 1964 graduating class of the University of Michigan Medical School have decided to intern at Ann Arbor, Dearborn, Detroit, Grand Rapids, Grosse Pointe, Kalamazoo, Lansing, Midland, Pontiac, Royal Oak, Saginaw and Traverse City.

Of the 172 members of the class of 1964, 83 will take their internship training in Michigan. Another 74 will intern in hospitals outside Michigan and 15 will be in hospitals operated by the armed forces and the U. S. Public Health Service.

Of the seniors, 130 received their first choice internship appointments in the National Intern Matching Program which coordinates the desires of the students with the selections of the hospitals offering internship training. This is 75 per cent of the graduating class.

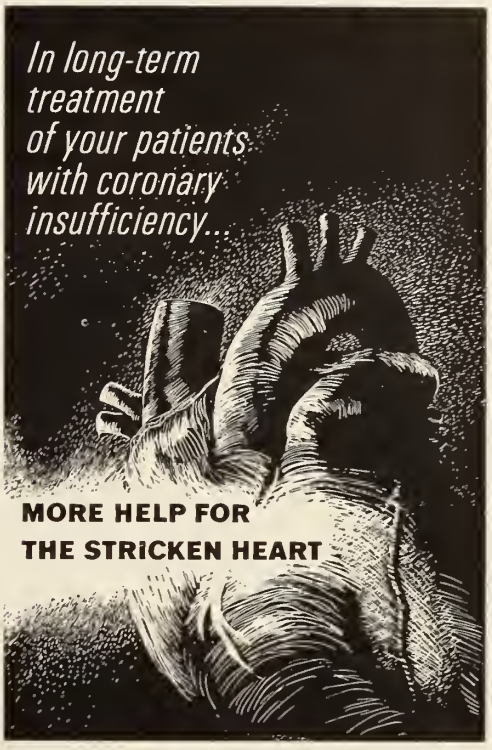
Eighty-two per cent of the seniors selected rotating internships in which they will receive training in several medical specialties, 12 chose internal medicine, five surgery, three pathology, one pediatrics and five mixed programs.

Ten seniors will intern at University Hospital and eight at Ann Arbor St. Joseph Mercy. Detroit was selected by 12 seniors, Grand Rapids by 9, Kalamazoo by 13, Saginaw by 9, Traverse City by 6, Midland by 3, Lansing by 2. Grosse Pointe, Dearborn, Pontiac, and Royal Oak will each have one U-M grad.

Summer Camp Available For Diabetic Children

MSMS members are reminded by the Michigan Diabetes Association to urge diabetic children to go to Camp Midicha, August 2-23.

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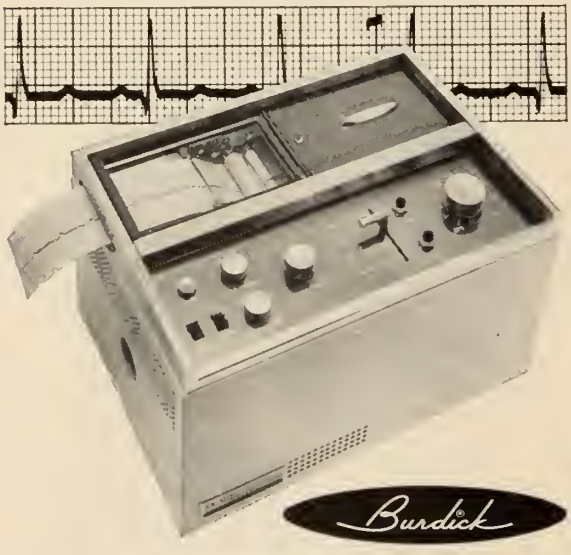
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tion fee, and the cost per camp period is $45.00. "Campership" are available for those children whose parents cannot provide the fee. Patients and their parents may write to Michigan Diabetes Association, 3919 John R, Detroit 1.

The medical care program fits innocuously into the camper's day, with doctors, nurses, and dietitians participating in the high physical activity program. The children who have other handicaps are not turned down as long as they can participate in the activities.

Plastic Surgery Academy Re-Elects

Recently re-elected as president of the Michigan Academy of Plastic Surgery was Ralph Blocksma, M.D., of Grand Rapids.

Returned also for another year was Harold W. Jaffe, M.D., Detroit, the secretary-treasurer.

Psychoanalytic Society Meets

The Detroit Psychoanalytic Society recently heard a paper by James C. Moloney, M.D., on "Love Blocks Transference." Jean B. Rosenbaum, M.D., serves as program chairman.

Advance Registrations Requested For WSU Alumni Event, May 20

Jacob F. Wenzel, M.D., Detroit, President of the Wayne State University College of Medicine Alumni Association Board of Governors, urges interested members to register in advance for the 96th Annual Clinical Program and Alumni Reunion Banquet, May 20, at the Sheraton-Cadillac Hotel. Detailed program information appeared on Page 301 of the April JOURNAL MSMS.

(*More Ancillary News, Page 388*)

Placement Service in News

A comprehensive article explaining the Placement Service of the Michigan Health Council appears in the March, 1964, issue of the national publication, *Veterinary Economics*. The illustrated story, by John A. Doherty, MHC Executive Secretary, told about the successful efforts of the MD Placement Service to place 580 doctors in 10 years and more than 100 doctors of dentistry and veterinary medicine in Michigan communities.

Say you saw it in the Journal of the Michigan State Medical Society

V. A. **MARKS, M.D.**, Midland, was campaign chairman to sell 250,000 shares of stock at $1 per share for the Midland Economic Development Corporation. . . . **JOSEPH J. REICHMAN, M.D.**, who had practiced at Mount Clemens since 1935, has joined the staff of the Saginaw County Hospital as chief of the Chronic Disease and Rehabilitation Section. . . . A speech about "Christian Marriage—Fight for Survival" was presented by **LINUS J. MAINO, M.D.**, Detroit, at the 25th Annual Convention of the Detroit Archdiocesan Council of Catholic women. . . . The medical section of the recently dedicated Genesee County Department of Social Welfare is a memorial to **DONALD R. GRADY, M.D.**, who had been instrumental in helping formulate the plans.

Speaking in Toyko recently was **JOHN STERLING MEYER, M.D.**, Birmingham, who discussed "Treatment of Cerebrovascular Disease before the Japanese Neurological Congress. . . . Her 39 years of practice were recalled by **RUTH E. WAGNER, M.D.**, first woman doctor in Royal Oak, now retired, in an address to the Ezra Parker DAR in Royal Oak. . . . Moving this summer to the American Samoa will be **P. J. VAN KOLKEN, M.D.**, of Grand Haven. He will be chief of medicine in the American Hospital at Pago Pago. . . . **GIANFRANCO DAL SANTO, M.D.**, is the new chairman of the Department of Anesthesiology at Wayne State. . . . **SIDNEY FREIDLAENDER, M.D.**, Detroit, has been appointed chairman of the Committee on Specific Therapy of the American Academy of Allergy.

Speakers at the "Conference to Plan Mental Health Nursing Services" at Michigan State University in April included **DONALD W. MARTIN, M.D.**, medical superintendent at Pontiac State Hospital. . . . **PETER BECKETT, M.D.**, Grosse Pointe Woods, and **RALPH D. RABINOVITCH, M.D.**, Northville, were among the speakers at the Michigan Academy of Pharmacy at Wayne State University in April.

Appearing recently on Michigan Health Council Television programs were **DANIEL REARDON, M.D.**, and **JOSEPH R. LENTINI, M.D.**, both of Grand Rapids. The programs were aired over WZZM-TV, Grand Rapids. . . . **THOMAS M. BATCHELOR, M.D.**, a member of the State Board of Registration in Medicine, is the new president of the Detroit Board of Health. . . . **FRANK W. HOWARD, M.D.**, and **AUGUST F. BLIESMER, M.D.**, are members of the new Board of Trustees of the Berrien's Lake Michigan College. . . . **EDWARD FINE, M.D.**, Detroit, presented a paper, "On Stuttering," to the Detroit Psychoanalytic Society and Institute at the McGregor Memorial.

F. JAMES STUBBART, M.D., is chairman of the Muskegon County Cancer Society campaign to raise $27,000. . . . The new president of the Catholic Family Service at Bay is **JOHN T. GENECZKO, M.D.** . . . During the observance of "Salute the



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Women Who Work Week," the *Detroit Free Press* carried an interesting feature about **IRENE T. S. SUEN, M.D.**, associate physician at the Dodge Assembly Plant. . . . Firemen and ambulance drivers in Jackson attended a clinic with **JOHN W. RICE, M.D.**, giving instructions on how to handle heart attack patients. . . . The AMA scientific program will deal with "Heart Disease," June 24 in Chicago and **THOMAS N. JAMES, M.D.**, Detroit, will discuss "Cardiac Arrhythmias Associated with Ischemic Heart Disease."

Michigan Authors

G. A. Eadie, M.D., J. G. Mohner, M.D., R. J. Solomon, M.D., and **R. D. Aach, M.D.,** "Type E Botulism", *Journal of the American Medical Association,* February 15, 1964.

B. M. Schuman, M.D., M. A. Block, M.D., W. R. Eyler, M.D., and **Lucille DuSault, A.B.,** Detroit, "Hepatic Photoscan in Liver Abscess," *Journal American Medical Association,* March 7, 1964.

G. A. LoGrippo, M.D., B. R. Wolfram, M.D., and **C. E. Rupe, M.D.,** Detroit, "Human Plasma Treated with Ultraviolet and Propiolactone," *Journal American Medical Association,* March 7, 1964.

R. C. Bates, M.D., Lansing, "The Internist: an Interpretative Portrait," *Medical Economics,* March 9, 1964.

S. W. Trythall, M.D., Detroit, "The Premarital Law," *Journal American Medical Association,* March 21, 1964.

Nikolas Kazmers, M.D., Lakeview, "Preliminary Report on Treatment and Prophylaxis of Acute Pancreatitis With a Kallikrein-Trypsin Inhibitor," *American Journal Gastroenterology,* January, 1964.

Samuel L. Levin, M.D., and **Robert A. Scherer, M.D.,** Detroit, "Allergic Tracheitis, a Problem in Pediatric Allergy," *Annals of Allergy,* January, 1964.

Samuel J. Levin, M.D., and **Robert A. Scherer, M.D.,** Detroit, "Collapsible Trachea (Tracheomalacia), a Non-Allergic Cause of Wheezing in Infancy," *Annals of Allergy,* January, 1964.

H. B. Appelman, M.D., Detroit, "Untoward Reactions to Emulsion Therapy of Pollenosis," *Journal American Medical Association,* March 28, 1964.

Conrad L. Giles, M.D., Southfield, "Anterior Uveitis in Children," *Archives of Ophthalmology,* December, 1963.

Conrad L. Giles, M.D., Leon Jacobs, M.D., and **Marjorie L. Melton,** Southfield, "Chemotherapy of Experimental Toxoplasmosis," *Archives of Ophthalmology,* January, 1964.

IN MEMORIAM

SAMUEL A. BUTLER, M.D., 84, retired Pontiac physician, died March 17, 1964.

A graduate of the Detroit College of Medicine in 1907, Doctor Butler completed his internship at Harper Hospital. At the time of his retirement in 1953, Doctor Butler was senior physician at Pontiac State Hospital, where he had served on the staff for 44 years. He came to Pontiac State Hospital from Oak Grove Sanitarium in Flint.

Doctor Butler was a Life Member of the Michigan State Medical Society.

JOSEPH H. KERZMAN, M.D., 49, Huntington Woods surgeon, died March 15, 1964.

A native of Switzerland, Doctor Kerzman was a 1931 graduate of the University of Michigan Medical School. Memberships included the Detroit Surgical Society and the American College of Surgeons.

FRANK MacKENZIE, M.D., 72, Detroit physician for 38 years, died March 8, 1964.

A native of Ontario, Doctor MacKenzie was graduated from the Detroit College of Medicine. He was a Fellow of the American College of Surgeons and was on the staff of Harper Hospital.

Doctor MacKenzie was a Retired Member of the Michigan State Medical Society.

C. W. PRESTON, M.D., 63, Detroit physician since 1926, died February 24, 1964.

Doctor Preston was graduated from Howard University School of Medicine in 1925, returning to Detroit where he practiced until his death.

JAMES MILTON ROBB, M.D., prominent Detroit physician and surgeon and a Past President of the Michigan State Medical Society, died March 23, 1964.

Doctor Robb was a 1908 graduate of the Detroit College of Medicine (now Wayne State University School of Medicine) and served his internship at Harper Hospital. He studied at the University of Vienna, London's Moorfield Eye Hospital, and the University of Edinborough. A nationally-known eye, ear, nose and throat specialist, for many years he was chief of that department at Receiving Hospital, where he also had served as chief of staff. Senior surgeon at Harper Hospital at the time of his death, Doctor Robb was formerly a chief of staff and head of the eye, ear, nose and throat department. He was also head of that department at Herman Kiefer Hospital.



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County Medical Society, the Detroit Academy of Medicine, the Detroit Otolaryngological Society and the American Academy of Ophthalmology and Otolaryngology. He served as President of the Michigan State Medical Society in 1932 and was a Life Member of MSMS. He was a Life Member of the American College of Surgeons and a Fellow of the Royal College of Surgeons in Great Britain.

MILTON C. SMITH, M.D., 76, Mount Clemens, Macomb County physician for 50 years, died March 13, 1964.

Doctor Smith was graduated from the University of Michigan Medical School in 1913, and practiced in Romeo for several years before entering military service during World War I. In 1919, he began practice in Mount Clemens where he practiced until his death.

He was a Life Member of the Michigan State Medical Society.

CASIMIR F. STANISZEWSKI, M.D., 51, Detroit, died March 5, 1964.

A graduate of Wayne State University College of Medicine, Doctor Staniszewski was director of the TB outpatient clinic of the Detroit City Health Department. He had been with the Health Department since 1955. He was a member of the National and Michigan Thoracic Societies and the Michigan Association of the Professions.

FREDERICK D. TRAUTMAN, M.D., 62, Frankfort physician and surgeon for 29 years, died March 12, 1964.

A 1933 graduate of the University of Michigan Medical School, Doctor Trautman served his internship and residency at University Hospital before beginning practice in Frankfort. He was chief of staff at Frankfort's Paul Oliver Hospital.

GEORGE P. WOOD, M.D., 70, Detroit physician, died March 20, 1964.

Doctor Wood was graduated from the University of Michigan Medical School in 1919. At the time of his death he was on the medical staff at Marygrove Clinic in Detroit.

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Correspondence

Dear Editor:

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JEAN B. ROSENBAUM, M.D.
19200 Canterbury Road
Detroit, Michigan 48221

•

Dear Doctor Johnson:

I was pleased to be invited to the MSMS County-Secretaries Public Relations Seminar and to be again in Michigan to participate in this important program. I enjoyed visiting with you and other fellow physicians and members of your staff.

I should like to comment that the move to make awards to outstanding citizens was an excellent one.

Best wishes and call on us if we can be of assistance in the future

F. J. L. BLASINGAME, M.D.
Executive Vice President
American Medical Association
Chicago, Illinois

•

Dear Editor:

The Michigan Society of Neurology and Psychiatry through its Department of Postgraduate Training in Psychiatry is completing its third year of presenting courses for all non-psychiatrist physicians. The courses have been programmed so that the second year and the third year naturally followed the first, in the type of material and method of presentation. The more advanced the student physician becomes in his knowledge of psychiatry, the more rewarding has been his participation in the course as well as in his private practice. Our slogan may well be "ask the doctor who 'took' one." Our own reward is to witness the interest and enthusiasm of the participating physician.

The Department stands ready to start a new series of courses in your area or to present additional courses for those who have been with us in the past and/or to arrange a joint program with non-psychiatrist specialty groups. Our sole purpose is to serve the local needs in psychiatric training

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D. B. Ruskin, M.D., *Chairman,*
Department of Postgraduate Training in Psychiatry
Michigan Society of Neurology and Psychiatry

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•

Dear President Johnson:

Please accept my most humble thanks for the outstanding honor which the Michigan State Medical Society bestowed upon me at the Annual Awards Luncheon in Lansing, February 27. Your award, although presented to me personally, really belongs to the people of the great State of Michigan who have supported our efforts on behalf of the People-to-People Health Foundation so nobly represented by Project Hope.

May I also say that without the voluntary assistance of the medical profession, in services performed aboard the ship on medical missions and through their contribution in time and money here at home, the good ship *S. S. Hope* would never have become a reality to thousands of unfortunate people throughout the world.

Again, my most humble thanks for your great honor and with best personal regards, I remain

Sincerely yours,
Alvin M. Bentley, *Chairman*
Michigan Committee for Project Hope

Owosso, Michigan

•

Dear Editor:

"It is a sad experience for all physicians when confronted with . . ." an article such as "Excision of Carotid Body for Advanced Emphysema," by John L. Shek, which was published in the March 1964 *Journal*. Dr. Shek states in his paper that "this procedure has a definite place in the management of acutely distressed patients with advanced emphysema," yet he has presented no theory or convincing data to support this claim.

Cervical glomectomy has been promoted by Dr. Nakayama as a treatment for refractory bronchial asthma. The procedure has been championed in this country by Dr. Overholt, but even Dr. Overholt, in his most enthusiastic moments, has not suggested that the procedure should be used primarily to treat advanced emphysema. Although with effort, one can theorize how glomectomy might be of value in bronchial asthma where pulmonary function is only temporarily impaired by bronchial spasm, the evidence that it actually does is very weak. No argument based on physiologic principles has been advanced to suggest that this procedure would benefit patients with advanced emphysema. Yet Dr. Shek states, "Following the rationale that this is a resection of a chemo receptor sensitive to blood O_2, CO_2, and pH level and thus breaking a reflex cycle that has become harmful to the host because of pathological condition of the lung, cases were selected primarily among persons with advanced emphysema rather than purely allergic asthmatic patients." This is Dr. Shek's statement exactly as it appeared in the article. He goes on to make the statement, with which I agree fully, that ". . . this procedure has a dubious value in patients with allergic asthma."

Dr. Shek's suggestion that glomectomy be used to treat advanced emphysema is a rather radical one, which he supports with neither argument nor data. He relates that 39 patients have been treated, but there is no control series. In only four of the 39 cases does he present ventilatory studies, and he does not indicate whether the preop values were obtained before or after the patients had received the benefit of therapy of proven value, such as antibiotics, topical bronchodilators, postural drainage, and cessation of smoking. After operation, six patients did not improve, but we are told that the remainder did. These data are not adequate to justify the conclusion that ". . . this procedure (glomectomy) has a definite place in the management of acutely distressed patients with advanced emphysema."

Contrary to Dr. Shek's report, a great deal is known about the etiology, physiology and pathology of pulmonary emphysema. When this information is utilized, a rational treatment program can be formulated, which will greatly benefit most patients with pulmonary emphysema (see Noehren-T.H., "Pulmonary Emphysema," J.A.M.A. volume 182: page 889-893, 1962). Attention should not be diverted from such a program to glomectomy, a procedure for which there is neither theoretical nor experimental evidence to suggest it has a place in the therapy of emphysema.

Sincerely yours,

Robert F. Johnston, M.D.
Wayne County General Hospital

Select NY Speaker for U-M Class Day Ceremony, June 5

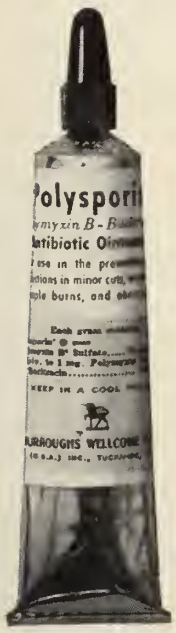
Joseph C. Hinsey, M.D., director of the New York Hospital-Cornell Medical Center in New York City, will be the principal speaker at The University of Michigan Medical School's 1964 Class Day Ceremony and Honors Convocation, June 5, in the Rackham Lecture Hall.

Candidates for the M.D. degree this year numbered 159 men and 15 women. William N. Hubbard, Jr., M.D., dean, will present diplomas and also present awards for achievement to selected students and faculty members. He will administer the Hippocratic Oath to the graduates, and all physicians in attendance will be invited to renew the oath.

Dr. Hinsey, former president of the Association of American Medical Colleges and presently chairman of its committee on financing medical education, is a nationally recognized medical educator.

The convocation speaker served in 1962-1963 as a member of a special committee studying the need for a third medical school in the State of Michigan. Deliberations of the committee were held in Ann Arbor. He has also served as a special consultant on future planning for medical education in California and Delaware.

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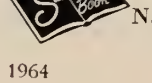
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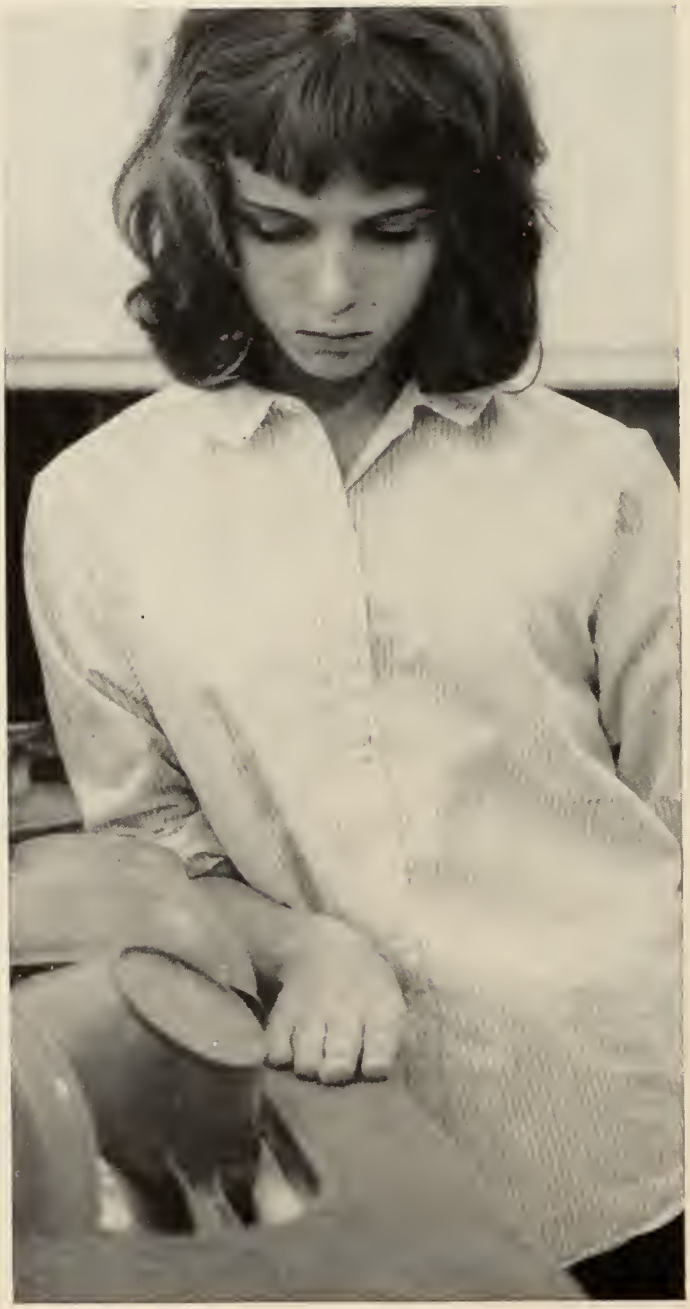
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References: 1. Szymanski, F. J.: *Indust. Med.* 30:498, Nov., 1961. **2.** Wexler, Louis: *Clin. Med.* 70:404, Feb., 1963. **3.** Hodges, F. T.: *GP* 14:86, Nov., 1956. **4.** McLean, I. E. D.; Graham, K. T., and East, M. O.: *Practitioner* 189:82, July, 1962.

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June, 1964

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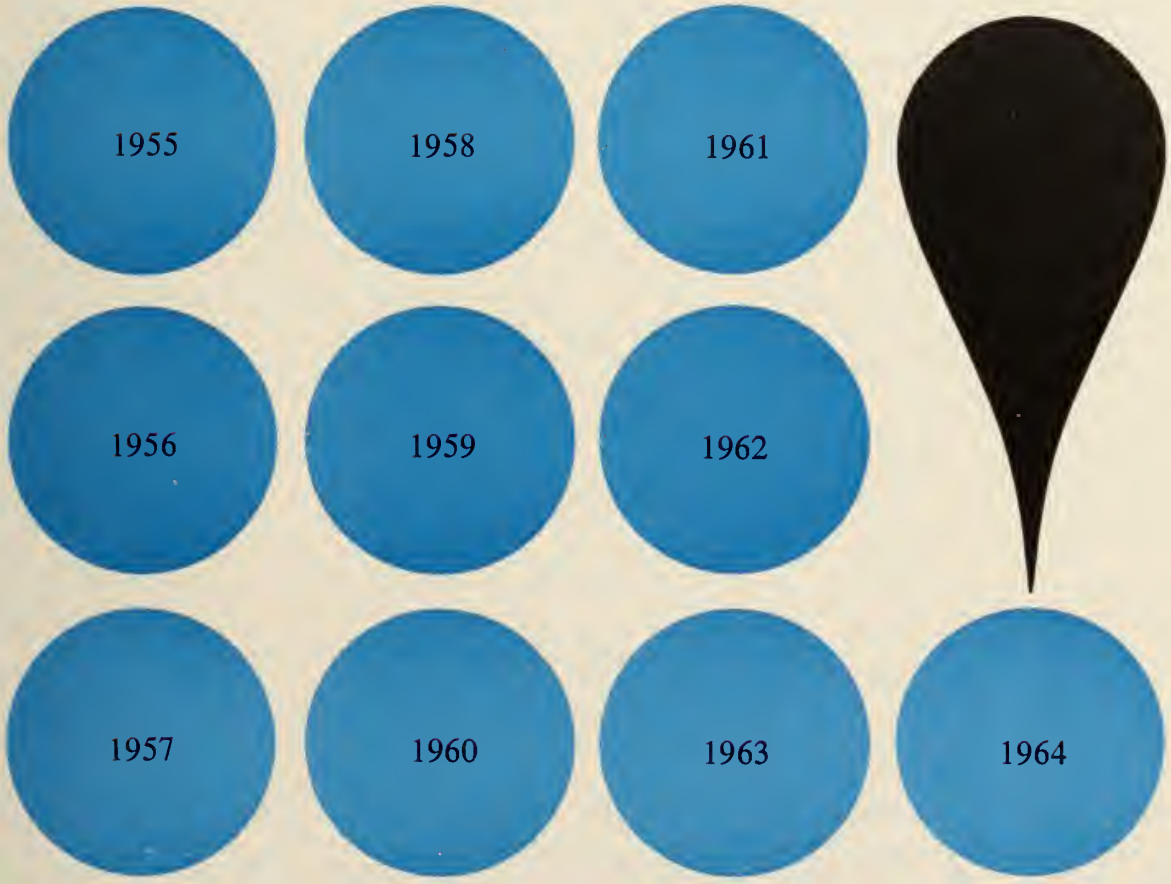
Delegates

	Term Expires
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G. W. Slagle, M.D., Battle Creek	1964
D. N. Sweeny, Jr., M.D., Detroit	1964
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L. R. Leader, M.D., Birmingham	1965

Alternates

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E. E. Martmer, M.D., Grosse Pte.	1964
R. E. Rice, M.D., Greenville	1964
A. Hazen Price, M.D., Detroit	1964
Sidney Adler, M.D., Detroit	1965
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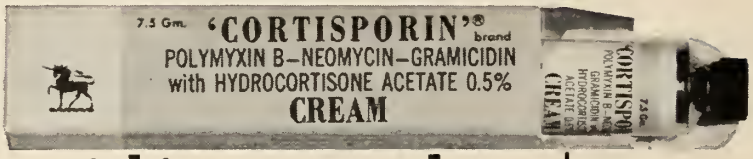
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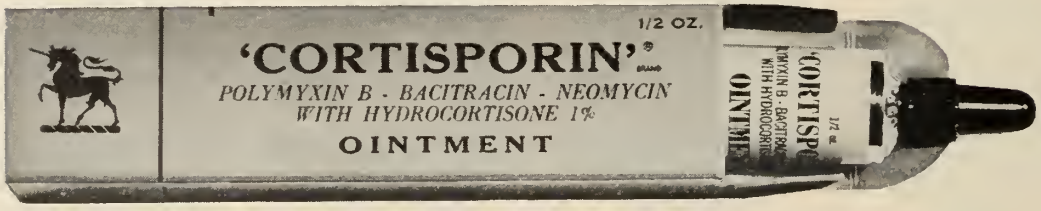
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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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QUALITY OF MEDICAL CARE



Orlen J. Johnson M.D.

President
Michigan State Medical Society

It seems ironical with the tremendous advances in medical science that quality medical care is an issue.

Health care consumers groups and the recently published study by the Commission on Health Care emphasize it. The MSMS House of Delegates recommended that the feasibility of a study of quality medical care be determined. A committee of the Council considered the problem with the conclusion there is no practical method for a factual study. An opinion survey known as the Kalamazoo Report indicated a preponderance of the public are satisfied with the care they are receiving.

The most likely area for factual determination is in hospitals. Even with staff organizations and rules there are no definitive measures of results of treatment of all cases. Monthly and annual hospitals reports are rarely no more specific than average length of stay by departments, percent of autopsies, fetal and maternal mortality and a few other figures. These reports contribute little to any evaluation of health care.

The extremists advocate the determination of quality of care in physicians' offices. The prime obstructions to such studies are invasion of privacy and interference with patient-physician relationship. In addition the technical difficulties appear insurmountable.

The advances in medicine through better bio-physiologic understanding have enhanced prevention, aided in diagnosis and made definitive treatment possible in many but not all areas. The intelligent application of the specifics in each phase of medical practice determines the success or quality of care. Though medicine still is not an exact science it is less dependent on the magnetism or personal attributes of the physician. However, any opinion survey reflects this latter factor more than scientific accomplishment.

The interest and influence of third parties (and the fourth—organizations representing patients) which have had such a profound effect on the economics of medicine are showing definite evidence of interest in quality of medical care. There can be no doubt that this interest will increase.

One of the earliest and greatest accomplishments of medical organizations was upgrading of medical education and postgraduate training. Not overlooking the commendable continuing activity in education and research, interest in the application of scientific medicine could well be a worthwhile and timely endeavor.

Now in operation on a limited basis are professional activities studies. An unlimited source of information under proper guidance, is the information now going on "punch cards" of medical care plans (Michigan Medical Service).

Under the aegis of medicine the proper guidelines can be set up for conclusions on the handling of specific diseases and procedures by each hospital staff or individual physician. Any significant conclusion could be transmitted to local medical societies. It is better that this be an activity of the medical profession. At present the above facilities are being used for quantitative measurements for economic control. Quantity should not replace quality or be the criterion of good medical practice.

Invite MSMS Members To Mental Health Congress In Detroit on June 26



Community mental health experts from New York, Illinois and Michigan will speak at the "Congress on Mental Illness and Health," to be presented by MSMS at the Statler-Hilton Hotel, Detroit, June 26.

All MSMS members interested in community mental health programming, and interested lay leaders and organizations are invited to participate.

Advance registration forms are available from MSMS.

* * *

THE PROGRAM FORMAT is explained by Edward H. Rodda, M.D., Bay City, Chairman of the Congress Program Committee, and also the MSMS Councilor from the 10th District.

Major addresses will be given by:

—**Marvin E. Perkins, M.D.,** Commissioner of the Community Mental Health Services of New York City;

—**Harold M. Visotsky, M.D.,** Commissioner of Mental Health in Illinois, and also a Director of the American Psychiatric Association's Committee on Manpower;

—**James G. Miller, M.D.,** Chief of the Psychiatric Research Institute, University of Michigan.

"The speakers and discussion groups will seek to both identify problems regarding community mental health and suggest general approaches to the problems identified," explains Benjamin Jeffries, M.D., Detroit, Chairman, MSMS Mental Health Committee.

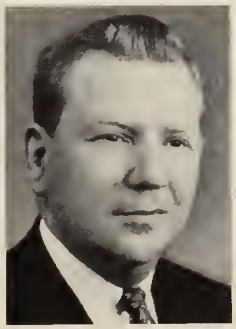
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"THE CONGRESS will be conducted with medical leadership, and will seek to involve educators, jurists, sociologists, psychologists, interested lay persons, and both medical and lay organizations," he continued. The Michigan Society of Psychiatry and Neurology and the Michigan Society for Mental Health will participate in the meeting with MSMS.

Registration is scheduled to begin at 8:30 a.m. with the first general session at 9:30 a.m. The several speakers will be presented in



M. E. Perkins, M.D.



H. M. Visotsky, M.D.



J. G. Miller, M.D.

the morning and at the luncheon with discussion groups and subsequent reports back to a plenary session from 2:00 until adjournment at 5:30 p.m.

All doctors who are interested and can arrange their work schedules are urged by Doctors Rodda and Jeffries to participate, if at all possible, in this new MSMS project.



Harold H. Hiscock, M.D. (*right*) Chairman of the MSMS Council, welcomes two new councilors at the May 20 meeting of The Council. At left is Don Marshall, M.D., Kalamazoo and at center, Edward H. Rodda, M.D., Bay City.

Doctors Rodda, Marshall Appointed to MSMS Council

Two newly-appointed councilors were officially seated at the May 20th meeting of The Council of the Michigan State Medical Society held at the MSMS headquarters in East Lansing. Edward H. Rodda, M.D., Bay City, fills the vacancy created by the resignation of Harold Kessler, M.D., Alpena, and Don Marshall, M.D., Kalamazoo, replaces William A. Scott, M.D., Kalamazoo, whose death occurred February 23, 1964.

Doctor Rodda, a graduate of Wayne State University School of Medicine in 1952, represents the 10th Councilor District, including the Alpena-Alcona-Presque Isle County Medical Society, the Bay-Arenac-Iosco County Medical Society and the North Central Medical Society encompassing the counties of Otsego, Montmorency, Crawford, Oscoda, Roscommon, Ogemaw, Gladwin and Kalkaska.

Doctor Marshall, who was graduated from the University of Michigan School of Medicine in 1952, will serve the component medical societies of Allegan, Berrien, Cass, Kalamazoo and Van Buren Counties as 4th District Councilor.

Doctor Rodda is a member of the Bay-Arenac-Iosco County Medical Society and Doctor Marshall is a member of the Kalamazoo Academy of Medicine and is a past president of the Academy. Both men are delegates to the MSMS House of Delegates and have been active in committee work of the State Society.

Presently Doctor Rodda serves as Chairman of the Mental Health Congress and Doctor Marshall is a member of the Committee on Emergency Care in Hospitals.

Doctor Marshall is an American Board Certified specialist in Ophthalmology with offices located in the Bronson Medical Center, Kalamazoo, and Doctor Rodda is engaged in the general practice of medicine at 101 W. John, Bay City. Both are married and active in local civic and community affairs.

The two men were appointed by The Council to serve until the Fall meeting of the MSMS House of Delegates.

Blue Cross-Blue Shield Begins Continuous Non-group Enrollment

For the first time in Blue Cross-Blue Shield history, the people of Michigan will be offered non-group coverage throughout the year. Continuous non-group enrollment became effective June 1, 1964.

It includes all Michigan residents who are under 65 years of age and cannot obtain coverage through group enrollment. Previously non-group subscribers could enroll only during a special two-week period each year.

This open enrollment is designed to extend health care service benefits to more individual subscribers under 65. There are no restrictions on eligibility. No physical examination is required.

Michigan Medical Meetings

June 26, MSMS Mental Health Congress, Statler-Hilton Hotel, Detroit.

July 30-31, Coller-Penberthy Clinic, Traverse City.

September 20-25, Michigan State Medical Society Annual Session, Sheraton-Cadillac Hotel, Detroit.

September 22-24, Woman's Auxiliary to MSMS Annual Meeting, Pick-Fort Shelby Hotel, Detroit.

September 23-24, Michigan State Medical Assistants Society Annual Meeting, Statler-Hilton Hotel, Detroit.

November 14-15, Michigan Allergy Society Midwest Forum, Ford Hospital Auditorium, Detroit.

(*Turn to Page 406*)



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Abstract of MSMS Council Action

Meeting of April 15, 1964

APPROVE SURVEY OF MICHIGAN REHABILITATION FACILITIES

The Rehabilitation Committee's survey plans and questionnaire were approved by The Council. The survey will seek information on existing rehabilitation facilities and services in all areas of the state.

DISTRIBUTION OF KALAMAZOO STUDY OF MEDICAL CARE AUTHORIZED

Printing and distribution of "Summary Report—Study of Medical Care in Kalamazoo" was authorized by The Council upon recommendation of the Medical Socio-Economic Committee.

RECOMMENDATION TO GOVERNOR RE APPOINTMENTS

With the advice of various committees, The Council approved recommending to the Governor certain nominees for appointment to the Michigan Commission on Aging and the Michigan Crippled Children Commission.

MEMBERSHIP IN U.S. CHAMBER OF COMMERCE

MSMS was authorized to renew its membership in the U.S. Chamber of Commerce for 1964.

IODIZED SALT EDUCATION CAMPAIGN

The Council approved plans for an education campaign in cooperation with other groups as proposed by the Iodized Salt Committee in October, 1964.

JOURNAL IMPROVEMENTS

The Publication Committee report was adopted which outlined many improvements in *The Journal* of MSMS. The new cover will incorporate the new title of the publication, "Michigan Medicine." A late news section will be added to THE JOURNAL.

COMMUNICATION WITH MSMS MEMBERS

The Council authorized publication of a monthly newsletter to all members between issues of THE JOURNAL, a news letter to component society officers two weeks following meetings of The Council. These would replace the current President's Letter, County Societies Letter and Legislative Report.

NEW MEETING ROOMS IN HEADQUARTERS

The Council authorized that two additional rooms on the second floor be converted to meeting rooms, to provide more adequate space for committee meetings.

REVIEW OF MSMS FISCAL YEAR

The Finance Committee recommended study of possible change of MSMS fiscal year to coincide with other internal operations of the Society.

REPORT OF MICHIGAN MEDICAL SERVICE

MMS President Sidney Adler, M.D., reported on (1) revised billing procedures, (2) merit rating, (3) access to hospital records, (4) outpatient services, and (5) frequency of use.

(Continued on Page 408)

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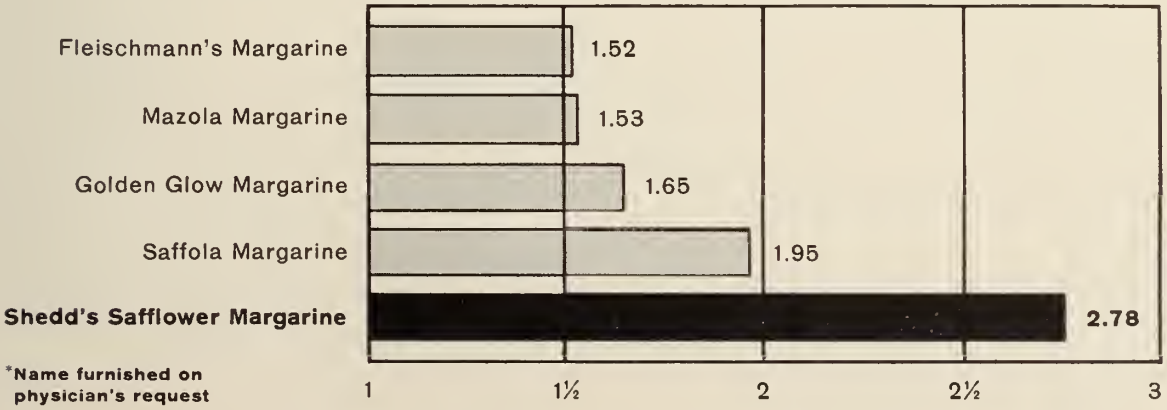


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Abstract of MSMS Council Action

(Continued from Page 406)

SUPPORT FOR SMOKING EDUCATION PROGRAM

The Michigan Department of Health budget request to create a smoking education program for Michigan youngsters was endorsed by The Council and will receive support in the Legislature.

ELECTION OF COUNCILORS OF FOURTH AND TENTH DISTRICTS

Upon the unanimous recommendation of the delegates in the Fourth District, Don Marshall, M.D., Kalamazoo, was elected to serve the unexpired term of Wm. A. Scott, M.D. (deceased) until the 1964 House of Delegates meeting, at which time he will be subject to election by the House.

Upon unanimous recommendation of the delegates in the Tenth District, E. H. Rodda, M.D., Bay City, was elected to serve as Councilor until September, at which time he will be subject to election by the House of Delegates to fill the unexpired term of Harold Kessler, M.D., who resigned.

COUNCIL HONOR TO WM. S. JONES, M.D.

The Council authorized the presentation of an award to Wm. S. Jones, M.D., of Menominee, for his service to organized medicine. The honor will be bestowed at a special dinner honoring Doctor Jones in Menominee on June 10.

MSMS Officials to Tour Upper Peninsula in June

An extensive tour in June of the Upper Peninsula, to confer with UP doctors, has been planned by leaders of the Michigan State Medical Society.

The first stop will be a luncheon meeting with the Chippewa-Mackinac Society members at Sault Ste. Marie on June 9, followed by a 3 p. m. stop at Newberry with Luce county members. That day will conclude with a dinner meeting at Marquette with the Marquette-Alger Society.

The schedule for June 10 begins with a luncheon meeting at Escanaba with the Delta-Schoolcraft doctors, followed by a dinner meeting at Menominee where W. S. Jones, M.D., MSMS past president, will be honored.

On June 11, the MSMS leaders will confer at lunch with the Dickinson-Iron doctors at Iron Mountain, and then speak at the Gogebic society dinner at Ironwood. On June 12, the travelers will visit in the morning at Ontonagon, and then stop at Houghton at noon with lunch with the Houghton-Baraga-Keweenaw society.

Making all or part of the tour for MSMS will be Doctors Orlen J. Johnson, president, and Harold H. Hiscock, chairman of The Council, and Hugh W. Brenneman, executive director.

Exhibits Popular At MSMS Meetings



The Project Hope exhibit attracted considerable attention at the MSMS Annual Session in Grand Rapids. Conferring at the exhibit are C. J. Maternowski, M.D. *(left)*, of Grand Rapids, and J. E. Rawling, M.D., Flint. The 1964 MSMS Annual Session will be held in Detroit, September 20-25.



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County Meeting Attendance Improves Under New Plan

By Alfred H. Whittaker, M.D., *Past President*

Wayne County Medical Society



At the beginning of the 1963-1964 year, it was noticed that due to lack of attendance at meetings, an effort should be made by the Wayne County Medical Society to increase attendance.

Consideration was given to the survey made by the AMA and reported in the County Society Responsibility booklet. This revealed a definite interest in the larger societies in medico-economics. As a result, several meetings were devoted to economic and legislative topics. Two meetings were devoted to Town and Gown, and development of the new Medical Center in Detroit.

In past years, the Detroit Society of Pathologists had met in the late afternoon on the day of the County Society meetings at the Society headquarters, but few, if any, pathologists stayed for the evening meetings. By arranging a 10-minute presentation of an interesting case by a member of the Society of Pathologists, the majority stayed for dinner and the County Society meeting. Most presentations added to the interest of the general meeting.

Adapting the so-called Dade County Plan, each of the WCMS meetings during the past year was preceded by a required quarterly staff meeting of a Detroit hospital. Without question, the attendance improved. This plan also resulted in many members of the Society,



Laboratory techniques employed at Gerber Hospital are explained by J. Paul Klein, M.D., president of the Newaygo County Medical Society, to high school students visiting the hospital upon invitation of the Society. The invitation was extended to students in the county schools to point up the opportunities for young people in medical and health careers. Watching Doctor Klein demonstrate the use of the centrifuge are *(left to right)*: Robert Frain, Newaygo; Carol Fritz, Hesperia; Carol Veenstra, Fremont, and Hesperia Principal, William Middleton.

who ordinarily did not attend, at least attending one meeting during the year.

Many WCMS activities are carried out by very hard-working committees. The interest in the content of the monthly County Medical Society meetings spilled over into the committee work, this being a valuable biproduct of the meetings.

I recommend to the new administration that the above described procedure be continued next year, as I believe the combined hospital staff-County Medical Society meetings are distinctly beneficial.

MUSKEGON HOSTS FLYING M.D.'S

Flying Physicians from five midwest states were special guests at the Muskegon County Medical Society "Trauma Symposium" this spring. Osteopaths from the Western Michigan area also attended upon invitation.

The Muskegon society annually sponsors this postgraduate training program with the Muskegon Chapter, Michigan Committee on Trauma, American College of Surgeons. In addition to speakers from Illinois, the program offered presentations by Robert W. Bailey, M.D., Robert E. L. Berry, M.D., and Wayne W. Glas, M.D., all of the University of Michigan. The symposium chairman was Emil J. Lauretti, M.D.

HURON PROTECTS 800 AGAINST TETANUS

More than 800 persons received preventive shots during the three-month Huron County Medical Society drive against tetanus. The Huron society urged all persons not immunized to use their family physician to get preventive shots.

GENESEE OFFERS CANCER AUTHORITIES

Once again the Genesee County Medical Society presented nationally-known medical authorities at its annual Cancer Day program at Hurley Hospital. James J. Lightbody, M.D., Detroit, MSMS Speaker of the House of Delegates, and H. Marvin Polland, M.D., Ann Arbor, presided. Speakers were brought to the excellent educational event from Illinois, New York City, Philadelphia and Texas.

CALHOUN GIVES SCHOLARSHIP

Addresses by Robert J. Samp, M.D., Madison, were presented by the Calhoun County Medical Society and the Calhoun County unit of the American Cancer Society at several community events, packed into one day. Doctor Samp, a popular lecturer about cancer detection and treatment, talked to the Central High School assembly, then at noon to Cancer Crusade workers and then at the Kellogg Community College. The medical society presented its Stuart Pritchard Memorial Scholarship to James Donald Pearson, son of Donald J. Pearson, M.D., and Mrs. Pearson, who leads the senior class of 538 with an all-A record.

WASHTENAW SUPPORTS FIVE-WAY IMMUNIZATION

Instead of conducting a county-wide oral polio vaccine campaign, Washtenaw County Medical Society focused its efforts on urging adults and children alike to visit their family physician or clinics for protection against smallpox, diphtheria, tetanus, whooping cough and poliomyelitis. The Washtenaw society pointed out there already was a high level of protection against polio and that there had been no cases of polio in the county in more than five years. Coordinated with the society effort, were well-infant clinics and monthly immunization clinics conducted by the county health department health center.

WAYNE COUNTY HOSTS DETROIT MAYOR



For the first time in many years, leaders of the Wayne County Medical Society hosted the mayor of Detroit for a luncheon-conference at the WCMS headquarters. The conference was arranged by Doctor Whittaker, who then served as WCMS president. Shown with Mayor Jerome Cavanaugh, third from left, are W. C. C. Cole, Sr., M.S., WCMS President; J. J. Lightbody, M.D., Speaker of the MSMS House of Delegates; Ray Girardin, Detroit Police Commissioner; Francis P. Rhoades, M.D., WCMS President-Elect, and Alfred H. Whittaker, M.D., WCMS Past-President. Mayor Cavanaugh is shown looking at a gift book, "Doctors Under Three Flags," a history about early M.D.'s in Detroit by Fannie Anderson.

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Under the pressure of modern living, with its "small continued anxieties of life,"[6] functional disturbances of secretion, tone and motility of the gastrointestinal tract are extremely common.[6,8] For the relief of symptoms associated with such disturbances—through rest for the patient, rest for the colon[3]—the drugs of greatest value have proved to be the antispasmodics and the sedatives.[3,6,7]

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*This one at Olympic National Park, Washington.

Can Idea of Free Enterprise Survive?

By C. T. Hardwick, Ph.D.



The freedom of the professional man is best provided in the free enterprise environment. This proposition would be subscribed to by most independent thinking Americans. Thus, it seems reasonable for professional men to inquire into the major ideologies underlying the American Free Enterprise System. In other words, what basic ideas, beliefs, principles and guiding rules have directed American development since our independence of 1776?

Students of the American scene will quickly agree that there is no monolithic or simple statement of our ideology although democracy, freedom, individualism, and dignity of man have persisted over the years. The form and practice of the American political economy have been modified and changed since the early statements of Hamilton, Jay, and Madison in "The Federalist." Nevertheless, some socio-economic traditions have contributed to the formulation of some national values.

Recently, Professor R. Joseph Monsen, Jr., of Brigham Young University has classified our beliefs and values into five groups of ideologies.[1] This presentation will briefly examine these five suggested major ideologies, namely: The Classical; The Managerial; The Countervailing Power; People's Capitalism; and Enterprise Democracy.

Of course in a pluralistic society like ours, no one ideology is dominant but rather, various groups embrace the beliefs that best express their own values. In a time of crisis, practical compromises are accepted so that a reasonable, unified action program is acceptable to at least a majority of Americans. Now let us review the tenets of these so-called American ideologies.

"Classical"

The oldest ideology explaining private enterprise has been conveniently labeled the "classical." It begins with Adam Smith's propositions of 1776 plus contributions of Ricardo, Mills, Malthus, and restated by Alfred Marshall in 1890. During the 19th, and early 20th century, most American politicians and businessmen preached the "Classical" line of individualism, free marketplace of supply and demand, private property, open competition, and limited government action.

Today, the U. S. Chamber of Commerce, the National Association of Manufacturers, and the Foundation for Economic Education are leading exponents of the principles of classical ideology. In 1962, Professor Milton Friedman of the University of Chicago, published a book called *Capitalism and Freedom*,[2] which advocated the remodeling of the U. S. economy along the lines of classical free enterprise. Many conservative politicians and economists parade the classical line which, like all ideologies, has its limitations in application to a particular set of circumstances in the 20th century.

"Managerial"

Because of widespread technology and big corporations of the mid-20th century, there has grown up a professional management class which has given rise to the second proposition which is labeled "The Managerial Ideology." In an over-simplified manner, this ideology proposes that the professional manager stands guard over the private interest and general welfare. Thus, the private incentives and gains are self-limited by enlightened managers aware of social and public responsibilities. No longer need we fear money-hungry free enterprisers because they have become trustees in behalf of workers and the general public.

The managerial ideology is in general a pragmatic approach to the world "as is." They see the necessity of big organizations as a real social system of customers, workers and leaders. Whereas government was viewed as a neutral umpire under the classical theory, the managerial theory accepts government as a playing-manager. In this context, government insures loans to business and plays an active role in preventing unemployment by counter-cyclical spending.

The Committee for Economic Development (CED) has often been a spokesman for the managerial ideology. It accepts big government, big labor, big agriculture, and big business and tries to work out some practical programs in the field of taxes, employment, and government relationships under the direction of managerial leaders.

"Countervailing Power"

Professor J. K. Galbraith has organized an ideology for America which has become known as the "Countervailing Power" theory.[3] In a brief argument, this theory contends that the free forces of the competitive market place have been replaced by organized power groups. That is, the economic interest of individuals has been superseded by economic interest of synthe-

Doctor Hardwick is Professor of Economics, University of Detroit, and Consulting Economist, Michigan State Medical Society.

sized power groups struggling for an equilibrium. In practice, it means a powerful force such as a few big *suppliers*, i.e., the rubber manufacturers, who will be met in the marketplace by some big *buyers* such as the automobile manufacturers who will bargain for a fair price. This theory presupposes that the rising of one powerful group will necessarily cause the growth of an opposing group which will achieve a fair result called an equilibrium.

In practice there is no such assurance but there is some evidence that such a teleology has some appeal in explaining American happenings.

"People's Capitalism"

In order to export American Capitalism in a favorable light, the U. S. Information Agency coined the phrase "People's Capitalism." The aim was to avoid the bad connotations of the older forms of capitalism. This new form of "People's Capitalism," puts the emphasis on the mass participation in "wealth getting" and "wealth spending." In a book called "The Capitalist Manifesto,"[4] Kelso and Adler propose widespread ownership by all Americans if we wish to avoid the welfare state. In general, they suggest a *capitalistic* redistribution of wealth before we slide into a *socialistic* distribution scheme.

Professor M. Salvadori, in a book called "The Economics of Freedom,"[5] also proposes some features of a "People's Capitalism." He suggests that the Market must not be operated by the state and that owners and managers must retain a great share of private decision-making power.

Furthermore, all Americans should be encouraged to become owners of more and more property and wealth, which makes them capitalists in the real sense.

The government should continue in its role of umpire and regulator of excesses and abuses by individuals and groups. Also, the government has the role to maintain the climate of political and economic freedom.

"Enterprise Democracy"

During the Eisenhower Administration, Arthur Larson assumed the position of presenting an ideology which he called "Enterprise Democracy." The details are set forth in his book called "What We Stand For."[6] This was not intended to be a view of one political party but rather a general statement of contemporary American beliefs which we might sell throughout the world. The central theme tries to explain the relationship between people, business, and government. Under the older ideas of capitalism, emphasis was often directed toward *conflict* groups. Now Larson places the emphasis on mutual dependence and cooperative efforts demanded in "Enterprise Democracy." All groups are encouraged to take advantage of freedom and work out a mutual arrangement and government steps in only when all voluntary efforts fail.

In "Enterprise Democracy," old ideas of freedom, private property, justice, individuality, morality, and private groups are revitalized into a national scheme of cooperation in which we avoid the artificial and monolithic domination of government. Although the concept of "Enterprise Democracy" appears vague and indefinite, it still adheres and subscribes to age-tried values which seem to demand more effort to protect before giving way to some other indefinite idea of the unproven welfare state.

Conclusions

The answer to the question—Can the Idea of Free Enterprise Survive?—is a strong affirmative if two conditions are met.

First of all, American leaders must recognize the essentials of their ideology and secondly, all Americans must work hard to make the "free system" out-produce the welfare state. The American mixture of private and public institutions is a difficult and confusing organization. However, as long as we remember the worthwhileness of freedom and independence, the rewards will be worth the efforts. In a free society, the leaders and followers have the opportunity and responsibility to decide what direction they wish to travel.

Today and tomorrow, America must decide whether the private sector will be preserved against the encroachment of the welfare proposals. The kind of capitalism we will have depends on this choice between private and public venture. The decision rests upon the shoulders of all.

Recently, the Chicago group, including Professor Milton Friedman, has been called the "New Individualism." This seems to me to be a good label to rally around if we still believe in the individual freedom, private marketplace, and limited role of government. It seems fair to say: "I must find my own answer—and you must do likewise."

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Asks Greater Understanding Of Newspaper Deadlines

"When the scientist complains that a newspaper story was obviously written in a hurry, it is because he doesn't understand the reporter's eternal race with deadlines."

So explained Frank Chappell, Director of Science News for the AMA, when he made the Sixth Annual Yates Memorial Lecture on Science News Writing at Michigan State University, under the sponsorship of the Michigan Tuberculosis and Respiratory Disease Association.

Mr. Chappell continued his comments about deadlines by saying, "A deadline is anathema to a researcher who may need 20 years to charm nature out of one of her secrets."

"The scientist often finds something to criticize in a newspaper story about his story. Some never cease to criticize; others learn that science and the news business have divergent points of view. When the scientist complains that the newspaper story dwells more on him than on his work, it's because he doesn't understand the newsman's basic interest in people. A basic tenet of science is to eliminate the personal equation as a disturbing factor."

* * *

"THE BASIC DIFFERENCE in viewpoint appeared to be this: scientists, science writers, and science readers were concerned with WHAT was being said in a story; editors were concerned with HOW a story was written."

Mr. Chappell also declared, "The science writer serves as mediator between the scientist and the science reader."

"The responsible and accurate science writer serves the scientific community in a role almost as important as the one he fills for the general public. He's a kind of intellectual bumblebee, carrying cross-fertilizing ideas between scientific disciplines."

* * *

"THE LAY PRESS CAN help scientists communicate with each other. More times than they like to admit, scientists have learned about research work in their own field by reading about it in a newspaper, or hearing about it on radio or television."

The AMA science writer made the observation that "Science writing is undergoing a change, from a predominantly reportorial function to one of interpretation and comment. A person without a great deal of education can handle the reporting job—and, indeed,



John Pettibone (*left*) treasurer of the Michigan Tuberculosis and Respiratory Disease Association and O. B. McGillicuddy, M.D., MSMS president-elect, join Frank Chappell (*right*), science news director for the American Medical Association, prior to the sixth annual Charles Yates Memorial Lecture at Michigan State University. The lecture series, co-sponsored by MTRDA and MSU, seeks to stimulate interest in science writing.

the ability to report accurately will always retain its cardinal importance in science writing. But only the broadly educated writer will be able to offer the intelligent interpretation and comment that a more sophisticated American public is already demanding."

Private Industry Contributes To Student Loan Fund

Private industry has donated more than $425,000 to the AMA-ERF Student Loan Fund. This support, together with generous contributions from physicians, has made it possible for thousands of medical students, interns and residents to obtain low-interest bank loans to help finance their medical education.

The views of medicine were effectively explained at a "Detroit Town Meeting" by Edward R. Annis, M.D., AMA President. WWJ-TV presented the program live for the auditorium audience and over its television channel to the vast metropolitan audience in their homes. Ven Marshall was the moderator.



MSMS Delegation Visits Michigan Congressmen

The annual four-day visit to Washington, D. C., by Michigan State Medical Society representatives was stimulating, informative and enlightening. The delegation was led by President Orlen J. Johnson, M.D. Others with Doctor Johnson were Brock E. Brush, M.D., Detroit, C. Allen Payne, M.D., Grand Rapids, and Frederick C. Sabin, M.D., of Marquette. Messrs. Hugh Brenneman and Ralph Wills accompanied the delegation.

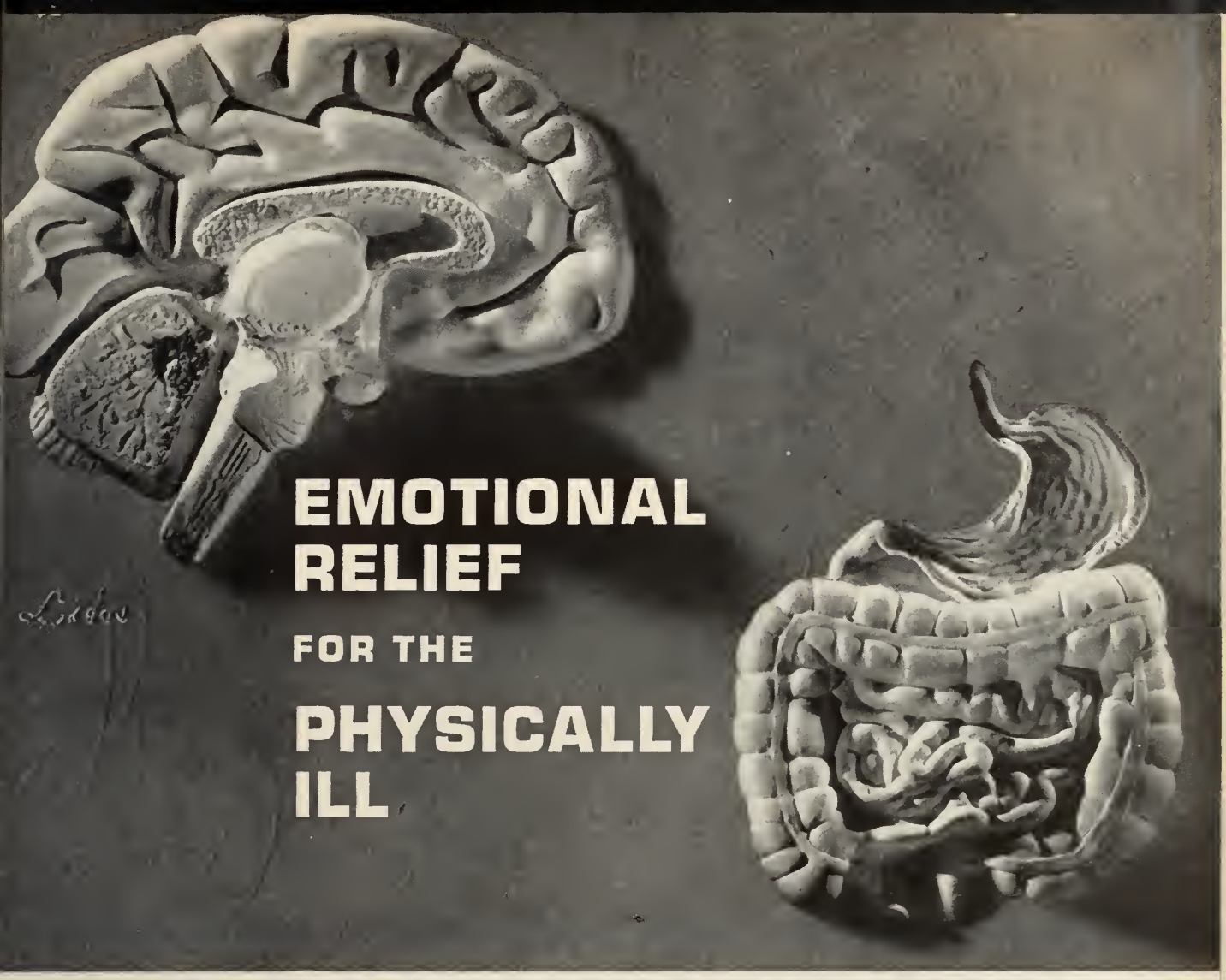
The offices of the Michigan Congressmen and U. S. Senators were visited by the delegation. Legislative views of the Congressmen and doctors were exchanged. Each Congressman visited expressed a growing concern over redistricting and its effect on his election campaign. Highlighting the trip was the well-attended 8:00 a.m. breakfast for the Michigan Congressional Delegation. Congressman Gerald R. Ford gave an excellent talk on the vital need of maintaining balance in government between the Legislative, Executive and Judicial branches.

Another breakfast was held for the Administrative Assistants of Congressmen. The doctors lunched with the Michigan-Capitol Press Corps.

Senator Everett Dirksen of Illinois left the Senate floor to visit with the delegation in his office at the Capitol. Senator Thruston Morton of Kentucky welcomed the delegation and said that if this Congress kept the King-Anderson bill bottled up, time was in favor of its final demise in subsequent Congresses. He spoke very highly of AMPAC. He declared he would not be in the Senate today were it not for efforts of the doctors and other members of the health team in his past election campaign.



WWJ, Detroit, brought both its TV newsreel and radio taping equipment to the Michigan Clinical Institute to help tell the MSMS story to the millions in the metropolitan area. Left to right, are Harry Lewis, radio engineer; Bob Stephens, sound man, and Hank Shurmur, cameraman.



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Contraindications: While the only absolute contraindications are tuberculosis, herpes simplex and chicken pox, there are some relative contraindications (peptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

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BIG HOSPITAL BILLS In Blue Cross - Blue Shield

Large hospital bills are becoming more and more common and therefore of increasing importance in health care economics. This paper describes a study of Michigan Blue Cross-Blue Shield members who incurred hospital expenses of over $1,000. Characteristics of Big Bill patients are discussed and results are given of a personal interview survey which determined the total health care expenses of Big Bill patients. The degree of coverage by Blue-Cross-Blue Shield is also described.

J. C. Woosley, Ph.D.
Detroit, Michigan

EVERYONE knows that health care costs have skyrocketed the last few years, due in the main to the increasing cost of inhospital care. The average citizen seems to be aware of the increasing use of hospital and physician services from his personal and family experience, experiences of friends and neighbors, and from the abundance of news stories and articles on this subject. However, not so much is known by the average citizen, as well as by many professionals working in the health care field, about some of the details related to this rising cost of care.

One topic which needs illumination for most people is the large hospital bill.

How real is the risk of having a $10,000 illness? Or even a $1,000 illness? Are these large hospital bills common enough to sound the alarm to "protect yourself against catastrophic illness" or has this risk been exaggerated by the insurance industry in the sales effort to promote major medical coverage?

Research Study Provides Data

A recent research study among members of Michigan Blue Cross-Blue Shield has provided some new data about the experiences of persons having large hospital expenses. This new information identifies some characteristics of persons in the "big bill" class, the kinds and amounts of expense incurred, both in and out of the hospital, and shows the degree to which their Blue Cross-Blue Shield coverage helped meet these expenses.

Big Bills of $1,000 or More

The research project undertook to analyze data on Blue Cross-Blue Shield members who had hospital bills of $1,000 or more. (For convenience in this report, these are referred to as *Big Bills.*)

Big Bills are a significant part of the total Blue Cross operation in Michigan, accounting for about one-seventh of the total payments to hospitals. For the year 1964, Big Bill cases will likely exceed $28,000,000. By way of comparison, it is of interest to note that this amount for Big Bills will be slightly larger than the total Blue Cross expense for all dependent children; or it will exceed by 50 per cent the total expense for maternity cases; and will almost equal the total expense for Group Conversion and Non-Group members combined. Thus, from the corporate viewpoint, Big Bills are a very substantial and important part of the total Blue Cross liability.

On the other hand, when the individual member looks at the threat of catastrophic health care expense he does not see the overall statistics as they appear to Blue Cross, but he sees a set of numbers that describe his own chances of a Big Bill.

For the past few years, Blue Cross admission rates have been approximately 160 cases per thousand members per year, which translates into one admission each year for every six persons. On the average, these

Doctor Woosley is Director, Research and Statistical Division, Michigan Hospital Service.

hospital cases have been staying about 8.5 days and incurring hospital expenses of about $300. Due to the nature of statistical distributions, a majority of the cases are under the average—that is, about two-thirds of the cases stay less than 8.5 days and have charges less than $300. However, everyone cannot be so fortunate and be below the average.

Two Thirds of Cost

The longer-than-average Blue Cross hospital cases represent only one-third of the total number of cases but over two-thirds of the total expense.

Further examination of the hospital bills shows that about one hospital case in 33 will exceed charges of $1,000. When this fact is related to the overall frequency of one admission per 6 persons, it becomes apparent that one out of every 200 persons can expect a Big Bill during the year. On the average this would mean one Big Bill each year for every 75 families. These odds are much more likely to happen than many other chances that a typical family takes during the year.

Characteristics of Big Bill Patients

A popular image of a Big Bill type of case is commonly that of a lingering cancer patient, 80 or more years of age, who undergoes repeated surgery, spends several months in an oxygen tent, and finally expires. Although part of this picture is true insofar as it describes some of the cases, Big Bill patients are not restricted to this category of age or ailment. The Blue Cross-Blue Shield research project studied a sample of patients who were known to have had a big hospital bill, and data were developed on their experiences for a twelve-month period, which included time before and after the hospitalization which generated the large hospital bill.

The study revealed a number of interesting characteristics of these patients.

Big Bill patients are heavily loaded with older age persons but this does not exclude younger folk from the risk of large hospital expenses. Persons age 65 and over in Blue Cross represent 7 per cent of the membership but account for 28 per cent of the Big Bills. Dependent children, on the other hand, are involved in 6 per cent of the Big Bills, which is a substantial figure though relatively low in proportion to their 40 per cent of the Blue Cross membership.

The severe illnesses that lead to Big Bills are frequently fatal. About one out of six Big Bill patients dies in the hospital during that same illness. On the other hand many are returned to useful lives completely cured, while others need rehospitalization. It is not uncommon for a discharged Big Bill patient to have several readmissions within the year, some of which may be an even greater expense than the first Big Bill.

One of the significant characteristics of these expensive illnesses is that, in general, they are not anticipated.

No Previous Hospitalization

Seventy per cent of the Big Bill patients in the study reported no previous hospitalization for the condition which caused this Big Bill. This is somewhat surprising in view of the nature of the Big Bill illnesses which showed conditions of the circulatory system to be the most frequent kind of case. Digestive system troubles and cancer cases were a close second and third. Not all patients, however, suffered from the dread diseases.

About one per cent of the Big Bill patients were complicated maternity cases, while such ordinary conditions as appendectomy and tonsillectomy cases accounted for half of one per cent.

The interrelationships of age, sex, and family status are important in describing the kind of patients who have large hospital expenses. Adult males on single Blue Cross contracts are heavily weighted in the older age brackets and this fact has a significant impact on hospitalization. Whereas these single-contract-males represent 5 per cent of the members and use 5 per cent of all hospital admissions, they account for 43 per cent of the Big Bill cases.

This is in sharp contrast to adult males on family contracts who are 24 per cent of the total membership but use only 4 per cent of the Big Bills. Members on the Senior Contract are found among Big Bill patients about twice as frequently as they are among all cases.

Big Bill patients generally are long-stay cases. Hospital stays of several months, or even a year or more, are not uncommon. On the other hand, some cases incur expenses of $1,000 or more in as few as four days in an intensive care unit. The average stay for Big Bill patients was 40.2 days for the particular admission selected in the sample, but repeated admissions by some of the Big Bill patients increased the total days used during the year to an average of 51.42 days per person.

Details of Expense Items

The patients who were selected for this study because of their having a large hospital bill were interviewed to determine total health care expenses for the

entire year for the condition relating to the Big Bill hospitalization. The following table shows the components of total expense as reported in the interview and verified, where possible, by Blue Cross-Blue Shield records.

AVERAGE CHARGES BY TYPE OF SERVICE FOR THIS ILLNESS DURING THE YEAR

Service	*Average Charge*	*Per cent*
Hospital, excluding X-Ray and EKG	$1,907	66.5
Surgery and Anesthesia	339	11.8
X-Ray and EKG—Inpatient	112	3.9
X-Ray, EKG, Lab, Tests, Etc.—Outpatient	28	1.0
Other Professional Services	264	9.2
Special nurse—hospital	39	1.4
Special nurse—home	39	1.4
Prescriptions—home	83	2.9
Appliances	4	0.1
Convalescent Home	23	0.8
Other Medical Expenses	28	1.0
Total	$2,866	100.0

Hospital care accounted for two-thirds of the total expense as would be expected. The expenses for other types of service are averaged over all patients, though of course all patients did not use all of these services. In fact a few patients had no physicians charges whatsoever due to professional courtesy. When charges for services are averaged over only those patients using that service, the impact of severe illness on an individual patient becomes much more apparent.

For example, in the data shown below, the frequency of use of special nurses and convalescent homes was low but the expense, when used, was great.

Type of Service	*Per Cent of Big Bill Cases Using Service*	*Average Charge When Used*
Surgery and Anesthesia	73.3	$463
Special Nurse in Hospital	8.5	471
Special Nurse at Home	7.8	499
Convalescent Home	3.2	727

The average expense of $2,866 varied slightly when examined by several subclassifications of the members. For example, a comparison by area shows an average of $2,744 for the city of Detroit, $3,340 for the remainder of the tri-county metropolitan Detroit area, and $2,598 for the outstate area. When classified by age, the average expense among Big Bill patients was $2,711 for dependent children, $2,863 for adults age 20 to 44, $3,061 in the age class 45 to 64, and $2,652 for persons age 65 and over.

It is of some interest to note that among the aged patients the average expense was much higher for females than for males: $2,471 for males compared to $2,896 for females. This difference between the sexes was due to a somewhat longer hospital stay for the women, who also consistently used better accommodations than did the men.

How Much Did MMS-MHS Cover?

Blue Cross and Blue Shield in Michigan have operated throughout the years on a policy that favors comprehensive first-dollar coverage. Benefits have been improved on both the hospital and professional side to the point where the great majority of members have comprehensive hospital coverage for 365 days and M-75 medical and surgical protection. A smaller segment, the Non-Group and Senior members, still have a contract limited to 30 days of inpatient care. The Master Medical coverage that Blue Cross and Blue Shield now offer was not in effect at the time of this research project, so an examination of the data will reveal the degree to which the basic hospital and medical contract covers the catastrophic type of illness.

The average health care expense for the Big Bill patients in the study was $2,866 of which Blue Cross-Blue Shield paid more than 80 per cent. Most of the out-of-pocket expenses were for items which were not contract benefits, such as special duty nursing, out of hospital prescriptions, and routine home and office calls by physicians.

Hospital charges accounted for two-thirds of total expenses for the year. On the average, Blue Cross paid 95 per cent of the hospital charges. Professional care by physicians accounted for one-fourth of the total expenses of these Big Bill patients during the year. On the average, Blue Shield covered two-thirds of these professional expenses notwithstanding the fact that much of the profesional care was not a contract benefit.

In general, the coverage that these Big Bill patients received from Blue Cross-Blue Shield was good.

Summary

This study has revealed some new data on Blue Cross-Blue Shield members who incur hospital bills of $1,000 and over. The fiscal impact on Blue Cross of this segment of utilization is of considerable magnitude. From the standpoint of the subscriber the risk of incurring a large hospital expense is too great to be ignored. Basic Blue Cross-Blue Shield coverage is providing good protection for these unusually expensive illnesses.

The Department of Physical Medicine and Rehabilitation at St. Joseph Mercy Hospital in Ann Arbor has developed a comprehensive rehabilitation program in conjunction with an active physical therapy, occupational therapy, and speech therapy service. With partial VRA support, a medical social worker, psychologist, vocational counselor, and prevocational evaluator have been brought into the department. Services have been rendered to the gamut of ages and disabilities seen in a large general community hospital. The effect has been to close the gap between the end of medical care and the beginning of psycho-social-vocational services when these are needed. The first 317 patients referred to the Rehabilitation Conference under this demonstration project are reviewed in the article.

Rehabilitation In a Community Hospital

Frederic B. House, M.D., Pieter D. Vreede, M.D., and Frederic M. Howes, M.S.

REHABILITATION in medical practice is the process of returning a person disabled by disease or injury to his optimum level of independence. This definition might well be used to describe the basic purposes of the entire hospital. Medical services are directed towards diagnosis and treatment of disease. Treatment includes elimination of causes and reduction of disability or complete restoration of function if possible.

When physical disability continues because of chronic disease or permanent impairment due to injury, then rehabilitation is largely a function of the restorative services of physical therapy, occupational therapy, prosthetics and orthetics.

However, even with these services, a sizeable number of patients in a general hospital (perhaps five per cent) are in need of additional services in order to obtain maximum independence.

Fills Many Purposes

Rehabilitation may take on different emphasis, depending on the person who is disabled. For the man of working age, this means employment if possible. Therefore, a rehabilitation service in a general community hospital must include vocational services if it is to render comprehensive rehabilitation services to this group. For the oldster, it means a home with necessary help and financial security. For this group, the rehabilitation program must emphasize the efforts of the Medical Social Worker. For the preschool and school age child, it means continuing in school and anticipation of vocational needs. The hospital program to serve this group must have available psychological evaluation and family counseling as an essential part of the rehabilitation service.

In reality, then, a community hospital that intends to serve children, working age people, and oldsters must, if it is to be comprehensive, have representative

FREDERIC B. HOUSE, M.D.

Author



From the Department of Physical Medicine and Rehabilitation at St. Joseph Mercy Hospital in Ann Arbor. Frederic B. House, M.D., Medical Director; Pieter D. Vreede, M.D., Assistant Medical Director; Frederic M. Howes, M.S., Vocational Counselor.

services in the area of medical social work, psychological services and vocational services, in addition to the regular medical care and restorative services usually found in general hospitals.

Report of Two-Year Study

Two years before the preparation of this report, we set out upon a supported project* to prove the feasibility of comprehensive rehabilitation in an acute care hospital. We are now ready to report our findings on this two-year effort. Although conclusions are hard to establish, it is possible to show that in a number of cases the time lapse between the onset of disabling injury and the return to useful employment or suitable home or school arrangement has been shortened because of the service. This saving in time results from closing the gap between the end of medical care and the beginning of psycho-social and vocational services necessary in the more complicated disability problems. Some of the shortening also results from the use of psycho-social services concurrent with medical care. Such services become available when a comprehensive rehabilitation program is provided as one of several hospital services.

It can also be demonstrated that these services can be performed effectively in a general hospital. It should be understood that rehabilitation services, other than restorative measures from occupational therapy, physical therapy, and occasional use of psycho-social services as supportive of acute medical care, are rendered as outpatient services.

In May, 1962, we reported our plan of action and the basic characteristics of the first 71 patients referred for psycho-social and vocational services as part of a rehabilitation program. We now present 317 patients referred prior to July, 1963, with follow-up information extending at least five months after referral.

TABLE I. AGE DISTRIBUTION OF 317 CASES REFERRED FOR REHABILITATION SERVICES

Age	*Total*
0 - 15	25
16 - 19	26
20 - 29	46
30 - 39	61
40 - 49	60
50 - 59	58
60 - 69	21
70 - 79	17
80 - 89	3

TABLE II. DISTRIBUTION OF 317 REHABILITATION CASES BY TYPE OF DISABILITY

	Disability	*No. of Cases*
1.	Absence or loss of limb	73
2.	Arthritis and Rheumatism	15
3.	Asthma and other Chronic Respiratory Diseases	3
4.	Brain Surgery or Trauma	13
5.	Burns	3
6.	Cardiovascular Diseases	15
7.	Cerebral Palsy	9
8.	C.V.A.	26
9.	Congenital Malformations not elsewhere covered	0
10.	Convulsive Disorders	2
11.	Diabetes and other Medical Disorders	7
12.	Disorders of Organs of Movement	24
13.	Emotional Disorders	2
14.	Hearing Impairments	4
15.	Lower Back and Cervical Spine Syndrome	68
16.	Mental Retardation	8
17.	Multiple Sclerosis	5
18.	Muscular Dystrophy and other Degenerative Diseases of Organs of Movement	0
19.	Other Central Nervous System Disorders	3
20.	Peripheral Nerve Disorders	4
21.	Peripheral Vascular Diseases	0
22.	Poliomyelitis	2
23.	Respiratory Tuberculosis	1
24.	Speech and Learning Disorders	19
25.	Spinal Cord Lesions	5
26.	Visual Impairments	1
27.	Other Conditions	5
28.	Unknown Conditions	0
	Total	317

The coding of these patients is according to primary diagnosis only. Code #13 *Emotional Disorders* and Code #6 *Mental Retardation* was a secondary disability in many of these patients. Many patients had other secondary disabilities and others were multiply disabled.

Of the 317 patients, 245 were male and 72 were female; ages ranged from preschoolers under the age of two to oldsters beyond the age of 80. The largest concentration was between 30 and 60. (Table I).

Disability Categories

Table II shows the distribution of patients according to disability categories. All patients had, as part of their initial medical evaluation, a medical diagnosis in addition to categorization as noted in the table. Medical diagnosis was, in most instances, established by the referring doctor. We then categorized the patients into the groups shown so as to compare our case load with other centers doing work similar to

*This program has been partially supported by a Vocational Rehabilitation Administration grant.

TABLE III. GEOGRAPHIC SOURCE OF 317 CASES REFERRED FOR REHABILITATION SERVICES

County	*Number*
Contiguous Counties	
Washtenaw	164
Livingston	23
Oakland	9
Wayne	29
Monroe	5
Lenawee	12
Jackson	12
Outlying Counties	
Calhoun	9
Ingham	4
Saginaw	6
Berrien	3
Cass	2
Van Buren	2
Kalamazoo	2
Muskegon	4
Kent	3
Ottawa	1
Ionia	1
Eaton	2
Huron	2
Shiawassee	2
Hillsdale	1
Macomb	1
Genesee	1
Lapeer	1
Tuscola	1
Gratiot	1
Montcalm	1
Isabella	1
Bay	1
Gladwin	1
Clare	1
Osceola	1
Mason	1
Cheboygan	1
Delta	1
Ontonagon	1
Baraga	1
Marquette	2
Luce	1

ours. (Table II). This classification, consisting of a mixture of pathologic and functional diagnoses, is in the process of review and improvement by the Association of Rehabilitation Centers. For the hospital based center, a classification based on medical diagnoses would be more useful.

Geographic Source of Referrals

Since this rehabilitation program was designed to serve the needs of private practitioners of medicine at St. Joseph Mercy Hospital, Ann Arbor, rather than the needs of a voluntary or governmental agency, we have seen patients from varying distances from the hospital. Table III shows the geographic distribution of our cases. It is noted that most of them have come from Washtenaw County and the six counties that are contiguous with Washtenaw County. Some comments will be made regarding the importance of rehabilitation services close to the patient's home.

Source of Sponsorship

Table IV shows the source of sponsorship. It is interesting to note the number of patients in this type of situation who provide their own financial sponsorship for this extended service. This same situation has been noted in other rehabilitation efforts. There were 15 referring insurance companies, using this service. These were largely concerned with industrial injuries which were covered under the Workmen's Compensation Laws. Four different offices of the Division of Vocational Rehabilitation used this service with 43 of the 53 referrals coming from the Jackson office, which serves Washtenaw County.

Referrals

Our plan, as described in the previous publications, called for all referrals to come from the medical staff. In practice we have found that some patients are coming more directly from agencies, such as Workmen's Compensation, insurance carriers, the Welfare Department, and the Division of Vocational Rehabilitation. In these cases we have taken responsibility for securing a relationship with a member of the medical staff of the hospital. This is accomplished by a request that the patient be referred first to an appropriate member of the medical staff for cases coming from out-of-town. The process may occasionally be needed with local people coming for service. However, most of the local people are found to be known to members of the medical staff prior to application for services. These medical staff members are then kept informed of the rehabilitation planning. It is our belief that, because of the physician's unique position

TABLE IV. SPONSORSHIP IN 317 CASES REFERRED BETWEEN SEPTEMBER, 1961 AND JUNE, 1963

Private (self or family)	124
Insurance Company	90
D.V.R.	53
M.C.C.C.	23
Department of Social Welfare	11
Non-Payment	6
Veterans Administration	4
Employer	3
Mich. Soc. C. C. & A.	2
Clergy Fund	1
Total Cases	317

of responsibility, he must be given the prerogative of exercising control over the course planned.

Rehabilitation Conference

We have consistently made use of our Rehabilitation Conference. The Conference is made up of the department staff, members of the medical staff, and representatives of outside agencies. The Conference meets each week. Referrals are presented by medical findings and results of Medical Social Worker's initial interview. From this presentation, the Conference decides if our service is suitable to the patient's needs. If it appears that our services are inappropriate for the patient's needs, no further service is offered. If it is believed that our program can be of service to him, the Conference establishes overall objectives for him and orders services.

Services Available

Services offered by the department can be described as follows:

1. *Medical.*—To determine the extent of impairment and the possibility of reduction of impairment through the use of physical therapy, occupational therapy, or speech therapy. Medical direction of a restorative program may follow evaluation.

2. *Psychological.*—The Clinical Psychologist determines the intellectual capacity, aptitudes, personality characteristics, and vocational interests of the patient. This may be followed by medically directed psychotherapy or counseling if indicated by the findings and ordered by the Conference.

3. *Social Adjustment.*—The Medical Social Worker evaluates the patient's background, living conditions, and family relationships to determine if there are certain social factors or attitudes which would preclude the patient from obtaining maximum benefit from the other rehabilitation services offered. When possible, barriers are reduced by counseling.

4. *Physical Therapy Treatments.*—The physical therapists perform two major functions:

(A) Reduction of impairment or the elimination of pathology through treatments by physical modalities which include heat, light, sound, water, electricity, massage, and therapeutic exercises.

(B) Training to assist the patient in achieving his rehabilitation goals, i.e., gainful employment and/or greater independence in living. This is done by establishing and conducting muscle strengthening and coordination programs, gait training, and prosthetic training.

5. *Occupational Therapy Service.*—Like physical therapists, the occupational therapists help in the medical treatment of a patient by improving functional use of a part, such as recovery of a joint motion. For rehabilitation purposes, the occupational therapist helps the patient increase his skills, obtain proper use of a prosthesis or strengthen his work tolerance.

6. *Speech and Hearing Evaluation and Therapy.*—Speech and hearing defects are diagnosed and corrective action undertaken.

7. *Vocational.*—The Vocational Counselor evaluates the patient's regular work by questioning the patient, through information obtained from his employer or by actual on-site inspection. Through the history given by the patient, he obtains information regarding the patient's previous work records, the patient's attitude toward previous employers, and employer's appraisal of him. This information is combined so as to give the Rehabilitation Team a picture of the patient's work and of the patient as a worker. It may be followed by guidance and placement efforts.

8. *Prevocational Evaluation.*—The Prevocational Evaluator, who is a registered occupational therapist, determines by means of special tests the range of residual skills, learning ability, and work habits.

9. *Occupational Adjustment Program.*— Certain patients may be enrolled in a special work program, using hospital employment situations (work stations) as a learning device. This on-the-job rotational work program, under the direction of the Vocational Counselor, allows all members of the Rehabilitation Team to evaluate the patient in a real work situation. The physician, the psychologist, and the medical social worker may observe the patient's progress. Together with the prevocational evaluator, it offers a check on the accuracy of initial evaluations.

10. *Social and Psychological Counseling.*—The Clinical Psychologist is available to conduct individual or group psychotherapy counseling sessions where patient's emotional adjustment is hindering his profiting to the fullest extent from the rehabilitation

services rendered. These sessions may be conducted in conjunction with the work program or separately. The psychologist has available the consultation of a psychiatrist in this part of his work.

The Medical Social Worker also renders assistance in many areas; for example, financial assistance is explored, residential or custodial care arranged, appropriate housing and transportation is investigated.

Records

Record keeping becomes a major problem in rehabilitation activities. There is always a considerable amount of written material on the patient served. Since material comes from several different disciplines in addition to medicine, record keeping becomes somewhat different than record keeping in ordinary medical practice. After considerable trial with various methods, we have developed a unit record for each patient. This record keeps the results of medical evaluations done in the department in addition to medical information coming from sources outside the department. The results of all evaluative procedures done by the social workers, psychologist, prevocational evaluator and vocational counselor are recorded. The result of each conference held on the patient is properly recorded in the chart and the results of any telephone conversations or other follow-up information on patients are made available in the patient's unit file. Finally, a running summary of these patients is kept so that, when they are reviewed by members of the medical staff or other authorized persons, the entire picture of the patient can be obtained without resorting to individual reports of examinations and correspondence. This summary is put on a two-page folio which is placed at the beginning of each patient record. In essence, the summary describes the patient at the outset of services. This description indicates his limitations as found by the physician, psychologist, social worker, vocational counselor, and prevocational evaluator. Following this is a running record of the services rendered. The description of the patient at the conclusion of services is done so as to point up changes brought about. Finally, there is a summary of the disposition of the case. The records for inpatients and outpatients are the same. Our information duplicates some of the information on the hospital chart in cases of inpatients.

Follow-Up

Due to the continuing nature of this type of service, follow-up becomes an increasing burden as the roster of patients becomes longer. One continues to lose contact with old patients under the pressure of new work.

The first line of defense against losing contact is attention to the missed appointments. This is done by our secretaries. Secondly, all new referrals are listed and presented to the Hospital Medical Staff Rehabilitation Committee each month. The department staff is prepared to identify the whereabouts or status of each one. At the end of six months after referral, a patient's chart is reviewed by several members of the department staff. Cases deliberately closed are removed from the active file. The active ones are then flagged so as to assure continuing follow-up. Those who are on the amputee program are brought in at least every six months for review of status. Current cases are noted, such as ones who are continuing to receive services, such as training programs; all others, where current information is not available, are flagged for immediate inquiry as to status or for inquiry at the end of one year after initial referral.

In this manner, we make reasonable attempts to follow up on all cases not deliberately terminated.

TABLE V. RESULTS BASED ON EMPLOYMENT IN 226 REFERRALS OF EMPLOYABLE AGE

136	Patients currently employed or in training
83	were employed at time of referral and rehabilitation services were directed towards maintaining employment.
41	were unemployed at time of referral and rehabilitation services were directed towards return to employment (direct placement).
12	were unemployed at time of referral and now are in training as follows:
5	Michigan Rehabilitation Institute
5	Colleges and Universities
1	Business School
1	Beauty School
3	Patients in hospital work program
	Employment or training status not yet determined.
87	Patients currently unemployed
34	probably employable but at time of review were not placed on job
53	probably not employable due to absolute barriers, such as severity of physical disability, psychological abnormalities, or compensation factors.

Results

Rehabilitation efforts have tried many ways to identify success. Some relate final outcome to predicted outcome. This would result in one hundred per cent success if all failed to be rehabilitated, provided that failure was predicted. If more realistic criteria are used, such as employment, there is always the question as to whether the services rendered were responsible for this success. Table V sets forth 226

patients of employable age, using employment as the criterion of success. The remaining patients, making up the 317, are accounted for by retirees 33, children 38, dead 9, and unknown status 11.

Discussion

As said at the outset, few conclusive statements can be made concerning the results of this service. It can be stated that a comprehensive rehabilitation program in the general hospital is feasible and some conclusions can be drawn from these studies as to the nature and variety of rehabilitation problems encountered in an acute general hospital.

If one comes to the conclusion that vocational services are needed in a general hospital in order to provide adequate service to a certain small group of patients coming to the attention of doctors in the hospital, then the use of the hospital work stations, such as has been accomplished at St. Joseph Mercy Hospital, is an efficient way to provide this service. The injured worker, who becomes a problem in rehabilitation and cannot return to his former employment, is frequently hampered by factors other than medical impairment. This implies that the factors hindering his employment are psycho-social factors and, in order to be effective in combating these, one needs extended contact with the patient. One purpose of our work station program, where patients are employed by the hospital on a temporary basis, is that they are able to be with us on a day-to-day basis for an extended period of time. During this period, the physician, the medical social worker, psychologist, and vocational counselor can counsel them toward better adjustment to their disability and, in addition, are able to evaluate further their capacities as workers. It is no longer popular to plead with employers to hire the handicapped, but rather to present them with a worker who can do a job in competition with non-handicapped people. This fact can be ascertained only after long observation and tryout in many cases.

Physical therapy and occupational therapy, together with medical and surgical treatment, continue to be the services used most frequently in an overall rehabilitation program. This is related to the fact that restoration of function must precede the vocational services, and frequently, even in severe disability, maximum restoration of function alone allows the patient to resume an optimum place in his community. We estimate that, for every hundred patients needing physical therapy or occupational therapy, about five of them will be in need of the extended services provided by the psycho-social and vocational members of the Rehabilitation Team.

In our work with rehabilitation problems we have encountered in the general hospital, we have been impressed by the effectiveness of many medical practitioners in the matter of rehabilitation. Many doctors are in the habit of personally contacting sponsoring agencies when patients are in need of special services in order to have proper restoration of function. Contacts are established with the Welfare Department and the Division of Vocational Rehabilitation by many physicians. Other doctors go further and contact employers on behalf of their patients in an attempt to re-establish persons disabled from their regular jobs. This is not an uncommon practice in practices where a large number of cardiac cases are handled.

In general, the contribution of rehabilitation services in a general hospital is to provide this type of service for all doctors. It is also believed that the rehabilitation team is able to handle more complicated or time consuming cases than most physicians' offices are able to handle.

With our team, as presently constituted, we have found it almost impossible to succeed in rehabilitation of patients coming from a distance, such as the upper peninsula. Even locally, we believe our greatest need in vocational cases is to be in closer face-to-face contact with employers in order to effect placement. In attempts to effect better placement, we hope to work more efficiently with our local DVR Counselor and the Michigan Employment Security Commission. Because of our concern with costs in the hospital economy, we cannot foresee sending one of our staff into the community on this placement mission unless such a person could be wholly supported by the community.

Other needs noted in our two-year effort are establishing agreed upon criteria of success and finding ways for the physician to identify easily the person needing comprehensive services. The latter must be found so that practicing doctors can be more effective in closing the gap between the end of medical care and the resumption of maximum independence.

Our success rate may look poor to some. However, considering the fact that most of our clients, except the amputees, were ones who were the most difficult rehabilitation problems may make our figures appear more favorable.

Referring to Table V, we believe the service was satisfactory in the 136 now employed or in training. Close scrutiny might show that more favorable placement or placement more suited to the patient could have been obtained. However, these are judgment de-

cisions. Using the simple objective criterion of employment, these 136 cases were successful. Considering the 83 employed at the outset, we have followed an ancient medical maxim "above all, do the patient no harm." As far as we can determine, no patient was out of work or rendered unemployable as a result of these services.

The 87 patients unemployed shown in Table V point up a problem in placement. Part of this is related to automation and other socio-economic factors in the nation at large. We believe, however, that some could be placed by means of more effort in communicating with employers in the patient's locality. The 34 probably employable, we believe, point up the need for more community-supported effort in relation to placement.

The 53 shown to be probably not employable actually point to a service rendered by a comprehensive evaluation team. Conclusive identification of these people will prevent heaping upon them useless, expensive services and will direct efforts towards providing means of economic support for them other than employment. Since placing this label of "unemployable" on a person is comparable to a diagnosis of malignancy, it must be done with great care. It requires the services of the full team.

One is continually searching for criteria of rehabilitation potential identifiable in the early course of disease and disability. This work may be one of the great contributions of the hospital based rehabilitation center, as for instance, utilization of the non-medical, professional workers to help identify rehabilitation potential in the industrial back-injured patient at the time of his acute medical or surgical treatment. The victim of a cerebrovascular accident is also in need of a better way to help him set rehabilitation goals early in his acute phase. The hospital based rehabilitation team can help the practicing physician do this.

Finally, attention should be called to the ratio of trainees (12) to direct placements (41). Retraining is not always the best solution to a rehabilitation problem. Our efforts are usually directed toward direct placement. We believe that, in order to identify the person capable of retraining and subsequent successful employment, it takes our full effort including the use of the hospital work program. Furthermore, many who are found intellectually capable of retraining are not candidates for retraining because of socio-economic or age factors. Actually, our ratio of retraining to direct placement should be expressed by comparing the 12 trainees to the total direct placements plus those ready for employment, which is 75. This makes our ratio approximately one to six or 84% direct placements.

Summary

The hospital based rehabilitation center is able to provide comprehensive rehabilitation, including direct vocational services. Certain advantages accrue to the hospital based center, including continuing medical control and reduction of time loss between the time of onset of disability and the beginning of rehabilitation services. The work of the comprehensive rehabilitation service at St. Joseph Mercy Hospital in Ann Arbor during the period September, 1961 and July, 1963 is described.

Acknowledgments

The development of this program is a joint effort of the Medical Staff Committee on Rehabilitation and the members of the Rehabilitation Team. Special acknowledgment is given to the following: John C. Walton, M.A., Assistant Director of the program from September, 1961 to April, 1963; James G. Lyon, A.C.S.W., Medical Social Worker for the program September, 1961 to December, 1962; James A. Jones, Clinical Psychologist; Donald G. Bachman, A.C.S.W., Medical Social Worker; Robert Hughes, R.P.T., Chief Physical Therapist; Mary Newton, O.T.R., Chief Occupational Therapist; and Ann Wallace, O.T.R., Prevocational Evaluator.

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The Michigan Maternal Tissue Registry

A. James French, M.D. and Mary L. Marshall, M.D.
Ann Arbor, Michigan

Founding and Sponsorship

IN 1956, the Maternal Health Committee of the Michigan State Medical Society asked a subcommittee on Registry of Maternal Tissues to consider means of financing and housing a Registry of Maternal Tissues. The idea for a registry of this type apparently originated through conversations at Blodgett Hospital in Grand Rapids in February, 1955.

Co-sponsorship of the Registry was accepted by the Michigan Society of Pathologists in May, 1956. The MSMS Maternal Health Committee, the Michigan Department of Health, the Michigan Society of Obstetricians and Gynecologists and the Michigan Society of Pathologists are co-sponsors. The Michigan Association of Osteopathic Physicians and Surgeons also supports the activity of the Registry. The Registry is housed in the Department of Pathology at The University of Michigan Medical Center and directed by the Chairman of the Department who reports periodically to the Maternal Health Committee. It was established in 1957.

The purposes of the Michigan Maternal Tissue Registry are:

(1) to collect, diagnose, and study the tissues submitted from cases of maternal death in Michigan upon whom necropsies have been performed;

(2) to analyze and correlate the verified pathologic diagnoses with the clinical data so that the cases of maternal death can be more accurately evaluated;

(3) to supply pathologic material to qualified residents and physicians for professional education;

(4) to stimulate interest in securing more necropsies in cases of maternal death;

(5) to report regularly to the Maternal Health Committee, Michigan State Medical Society.

The files of the Department of Pathology at The University of Michigan Medical Center were reviewed and the Michigan Maternal Tissue Registry was started with some 130 cases from the above source dating from 1895 to 1957.

Additional material has been submitted from other hospitals with the support of obstetricians and pathologists so that more than 300 cases are now registered, as reported at the Maternal and Perinatal Welfare Conference sponsored by the Maternal Health Committee.

The following list will indicate the major diagnoses included:

I. *Inflammatory Diseases*			105 cases
II. *Hemorrhage or Related States*			64 cases
Hemorrhage		12	
Cerebral hemorrhage		10	
Amniotic fluid embolism		19	
Pulmonary arterial emboli		15	
Ruptured ectopic tubal pregnancy		8	
III. *Toxemia*			36 cases
IV. *Neoplasms*			33 cases
Carcinoma		11	
Breast	3		
Pancreas	3		
Colon	2		
Cervix	1		
Bronchiolar	1		
Parotid gland	1		
Choriocarcinoma		7	
Leukemia		7	
Brain tumors		5	
Melanoma		1	
Pheochromocytoma		2	
V. *Miscellaneous*			66 cases
Homicide, suicide, and other trauma		10	
Chronic rheumatic heart disease		6	
Hypoplastic anemia		5	
Renal cortical necrosis		3	
Congenital heart disease		3	
Anesthetic deaths		3	
Chronic glomerulonephritis		2	
Other diagnoses		14	
Incomplete data and/or no morphologic cause of death		20	

The members of the Maternal Health Committee of MSMS, Michigan Department of Health, and Michigan

From the Department of Pathology, The University of Michigan, Ann Arbor, Michigan.

Maternal Tissue Registry wish to express sincere gratitude to our colleagues in medicine for supplying the excellent material.

A teaching set including color photomicrographs and microscopic slides is being assembled. Material from the Registry is used to supplement a teaching set for residents in obstetrics and gynecology.

For the information of the participants in the Michigan Maternal Tissue Registry we again ask for the following:

1. Complete clinical, roentgenographic, and laboratory data on the mother throughout pregnancy and during and after delivery.

2. Clinical and gross photographs and photomicrographs whenever available. (The Registry will copy pertinent roentgenograms, photographs, and photomicrographs and return the originals to the physician who submits them.)

3. Necropsy protocol including gross and microscopic findings as well as clinical and clinicopathologic summaries.

4. Wet tissue and/or paraffin blocks from all organs sampled.

5. Microscopic slides from all organs sampled including special stains when made.

All material received will be acknowledged and all cases will be available for study under code numbers so that the identity of the patient, hospital, and physician will not be revealed.

Summary

1. The Michigan Maternal Tissue Registry was established in 1957 at the Department of Pathology, The University of Michigan Medical Center, by the Maternal Health Committee of the Michigan State Medical Society, co-sponsored by the Michigan Department of Health, Michigan Society of Obstetricians and Gynecologists, and Michigan Society of Pathologists. The Registry is also supported by the Michigan Association of Osteopathic Physicians and Surgeons.

2. Some three hundred necropsies are now on file and available for study by participants in the Registry and by others who may be interested.

3. This unique Registry will provide invaluable material for study and should emphasize areas for increased vigilance by the physician who cares for obstetrical cases.

4. The excellent cooperation between obstetricians and pathologists is most commendable.

Physicians' Smoking Habits Changing

More than 60,000 physicians have made it clear in a nationwide survey that U. S. medical opinion is nearly unanimous on one subject: cigarette smoking is dangerous.

Many physicians report they have changed their own smoking habits by stopping, cutting down, or switching away from cigarettes.

The survey was conducted by the medical journal, *Modern Medicine*. A questionnaire was sent to the 192,000 physicians in active practice, and was returned by 60,202—nearly a third.

Commenting on their own habits, 80 per cent said they have smoked at some time in their lives. At present, however, 52 per cent do *not* smoke, and many who continue to smoke use cigars and pipes. Only 22.5 per cent are now smoking cigarettes, and 89 per cent of these consider the habit a health hazard. Significant, too, is the fact that thoracic surgeons and pathologists, specialists most likely to get frequent, good looks at the lungs, rank at the very bottom of cigarette smokers.

Some Physiological Implications Of Gold in Serum and Urine Concentrations in Chrysotherapy

The concentration of gold in serum and urine was determined in five patients with rheumatoid arthritis on active chrysotherapy. The serum concentration of gold tended to reach a plateau of 150 to 300 micrograms per 100 ml. over a 21- to 35-day period after approximately 75 to 125 mg. of injectable gold had been administered. Toxic manifestations were present in two patients when the residual concentration of gold were above or near 300 micrograms per 100 ml. of serum. However, this tolerance level was reduced in a patient who had been on a long-term chrysotherapy. The urinary and serum levels are in agreement with previous studies using less sensitive means of analysis.

Jesse F. Goodwin, Ph.D.
Detroit, Michigan

SINCE the favorable report of Forestier,[1] gold salts have been employed as an adjunct in the treatment of rheumatoid arthritis. Freyberg, Block and Levey[2] administered gold to patients with arthritis and established that it was slowly eliminated in the urine, and that both blood and urine contained significant amounts of gold for a long time after its administration. The work of Freyberg and associates has been confirmed with radioactive gold.[3-5] No other reports, however, are available in which the actual serum concentrations of gold were determined during a course of therapy, primarily because of the lack of a micromethod sufficiently sensitive and convenient for repetitive determinations. The purposes of the present investigation were to test the efficacy of a recently devised micromethod of assay of gold in biologic fluids and to determine the concentrations of gold in the serum and urine of patients during and following chrysotherapy. Some information was also obtained about the levels of gold in the serum of a small group of patients with rheumatoid arthritis who displayed toxic effects.

Material and Methods

Five out-patients with typical rheumatoid arthritis who had active joint inflammation were studied during a three-month period. Gold sodium thiomalate (Myochrysin) was administered by intramuscular injection, and the doses were recorded as the total amount of gold injected. Samples of blood and urine were obtained at the same time from patients prior to administration of each dose of gold during the period of study.

The microcolorimetric method of Goodwin and Bollet[6] was used for the estimation of gold in serum and urine. All of the gold present in the blood was found in the serum, and determinations were therefore made routinely on serum only.

Results

Samples of urine and blood obtained from normal persons, who served as controls, did not contain gold when analyzed by the method used here. The results obtained from patients on chrysotherapy are indicated in Figures 1-5.

Supported by Grants from the Michigan Chapter of the Arthritis and Rheumatism Foundation.

From the Department of Medicine, Wayne State University College of Medicine and Receiving Hospital, Detroit, Michigan.

Doctor Goodwin's present address: General Clinical Research Center for Children, Wayne State University College of Medicine and Children's Hospital, Detroit, Michigan.

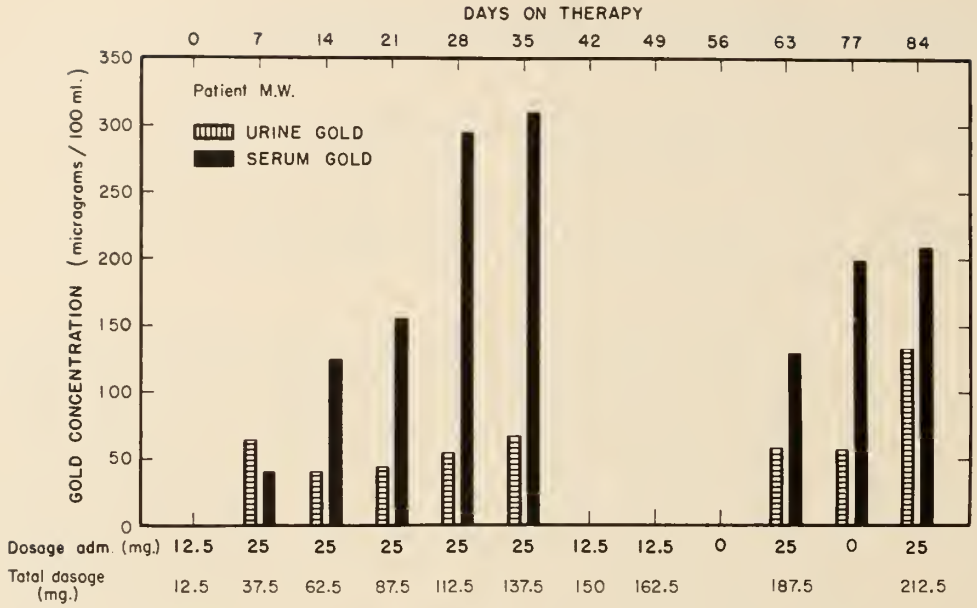


Fig. 1. Concentrations of gold in serum and urine in patient N.W., a 33-year-old woman.

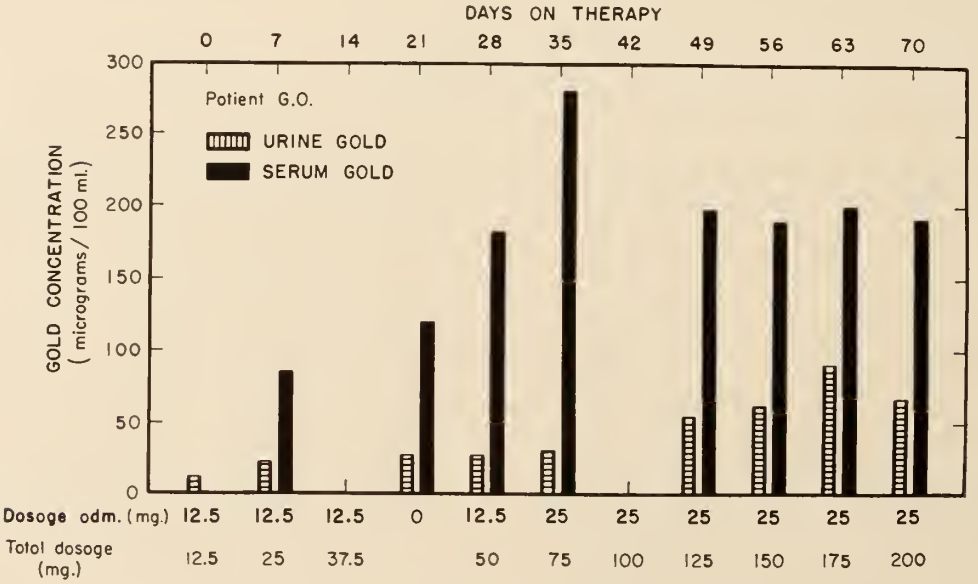


Fig. 2. Concentrations of gold in serum and urine in patient A.S., a 51-year-old woman.

The gold levels obtained in patient M.W., a 33-year-old woman with moderately severe rheumatoid arthritis, are characteristic (Fig. 1). She was given aspirin daily and an injection of gold weekly. Improvement was noted on the 21st day of treatment. Between the 35th and 42nd day, she complained of a "sweet taste" in her mouth. On the 35th day, the concentration of gold had risen to 310 micrograms per 100 ml. serum. Inasmuch as the patient continued to improve throughout therapy, gold injections were given biweekly after a total of 162.5 mg. had been administered. The patient's platelet count fell from 636,000 to 160,000 per cu. mm. of blood during the period of treatment. Other blood laboratory findings were normal. There appears to be some correlation between the concentration of gold in serum and urine in random samples of serum and urine obtained from this patient.

The findings (Fig. 2) in patient G.O. further emphasize the effect of accumulated doses on the concentration of gold in the serum. This patient, a 47-year-old woman, had previously been on gold therapy but after 275 mg. of gold had been administered the drug was discontinued because of leukopenia. When gold therapy was again administered 4 months later, no gold was detected in her serum but some was detected in a random sample of urine. Therefore, the

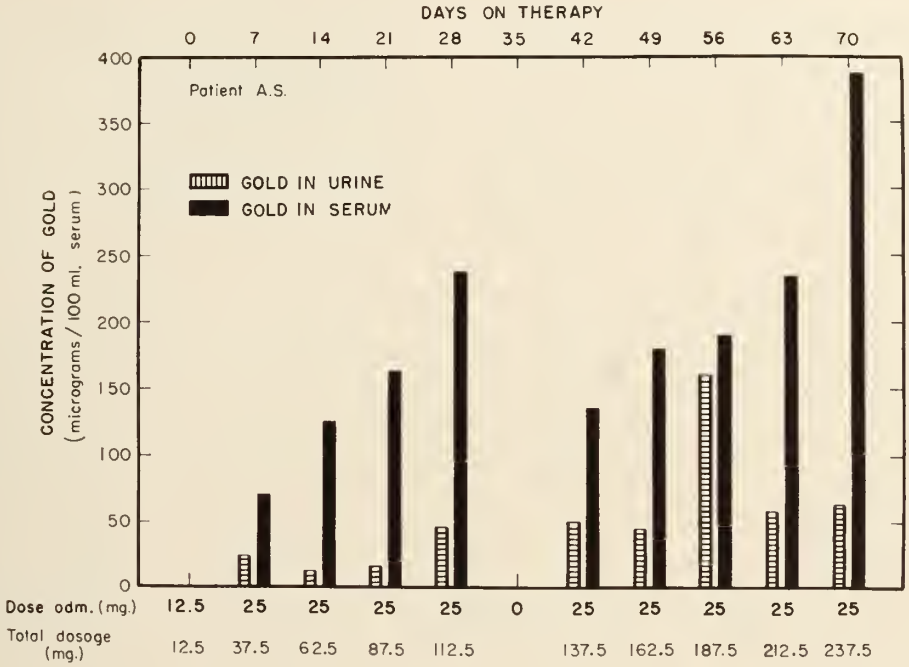


Fig. 3. Concentrations of gold in serum and urine in patient G.O., a 47-year-old woman.

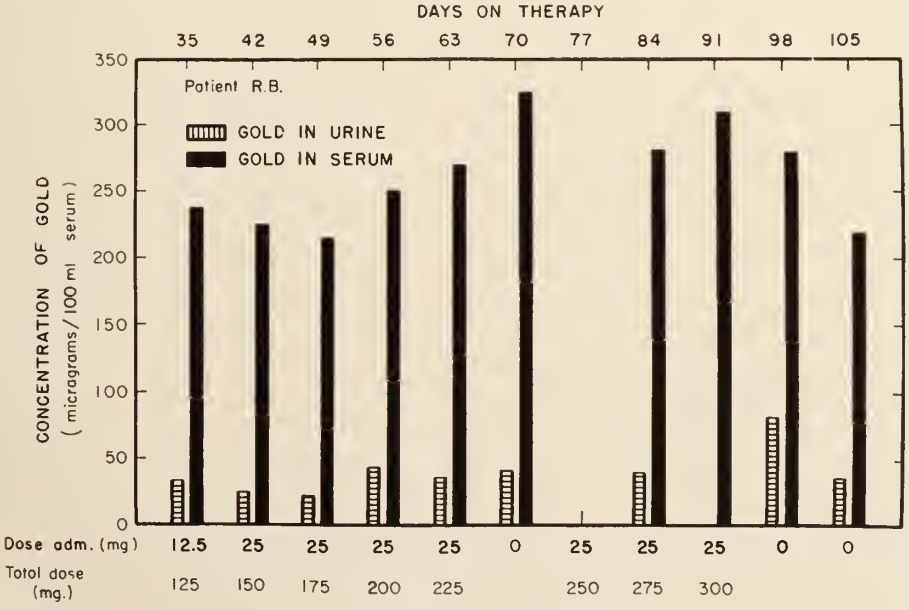


Fig. 4. Concentrations of gold in serum and urine in patient R.B., a 29-year-old woman.

zero starting date used is the date that gold salts were first administered during the second course of therapy. The patient had severe arthritis and no change was noted in her condition during this study. She developed hypochromic macrocytic anemia on the 21st day of therapy. Gold therapy was discontinued after the onset of edema of the chest and upper lip. At that time, she had been given 200 mg. of gold and had a gold concentration of 192 micrograms per 100 ml. serum.

Patient A.S. (Fig. 3), a 51-year-old woman, had severe rheumatoid arthritis with ankylosis of both wrists and limitation of motion of both shoulders and left ankle. She was given aspirin along with injections of gold. No improvement was noted up to the 21st day. Steroid therapy and physical therapy along with gold and aspirin were continued throughout the rest of this period. The patient reportedly showed signs of improvement on this regimen.

Typical were the findings (Fig. 4) in patient R.B., in

whom serum concentrations of gold reached an equilibrium and remained rather constant until the maintenance dose was reduced. This 29-year-old woman had received 112.5 mg. of gold before the current study was initiated. She had had rheumatoid arthritis for eight years, and her disease was moderately severe. She received aspirin along with weekly injections of gold. The dosage of gold was decreased to 12.5 mg. on the 35th day owing to a decrease of the white blood cell count. At this time, the concentration of gold was 238

Discussion

This preliminary study presents the pattern of concentration of gold in the serum and urine of 5 patients with rheumatoid arthritis receiving chrysotherapy. The results indicate that the micromethod devised for this purpose is sufficiently sensitive.

It may be pointed out that in two patients (R.B. and

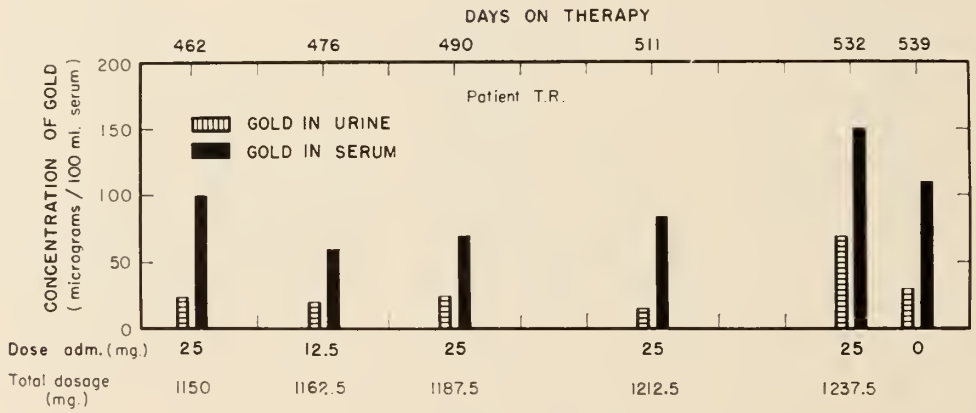


Fig. 5. Concentrations of gold in serum and urine in patient T.R., a 35-year-old man.

micrograms per 100 ml. of serum. The leukocyte count rose to normal during the following week. The patient again developed leukopenia on the 70th day at which time the concentration of gold had risen to 325 micrograms per 100 ml. serum. The value was 310 micrograms on the 91st day. A rash was noted on the 98th day at which time the patient had a concentration of 280 micrograms of gold per 100 ml. of serum. During this study, she stated that she was much improved, but it is doubtful that her improvement was entirely attributed to gold therapy since she had a history of remissions and exacerbations. Gold therapy was discontinued on the 147th day at which time she had been given a total of 3125 mg. of gold. The concentrations of gold in the serum and urine seemed to have a parallel relationship.

Figure 5 indicates the findings in patient T.R. which are typical for patients receiving gold at rather wide intervals for a prolonged period. This patient, a 35-year-old man, received gold, aspirin and steroid therapy during a period of 443 days prior to administration of gold. His arthritis was moderately severe and he had at times shown signs of improvement followed by occasional relapses. On day number 454, two days after receiving an injection of gold, he complained of severe swelling in the joints and fever, and these complaints persisted for four days. Thereafter, he maintained residual levels of gold around 100 micrograms per 100 ml. of serum while receiving a maintenance dose every two or three weeks.

In all of these patients, the concentration of gold in the urine tended to fluctuate in the same direction as the concentration of gold in the serum.

M.W.) toxic manifestations were present when the residual concentrations of gold were above or near 300 micrograms per 100 ml. of serum. This suggests that the critical residual serum gold concentration should be kept below 300 micrograms per 100 ml. of serum. These two patients also exhibited some signs of improvement during this study. In one patient (T.R.), a severe reaction was noted with a three-week residual concentration of 150 micrograms of gold per 100 ml. of serum.

The serum concentrations found are in the same range as those reported by Freyberg and associates[2] for patients receiving similar doses of gold. The finding of small amounts of gold in the urine four months after cessation of chrysotherapy also is in agreement with the data of Freyberg and his associates who utilized the method of Block and Buchanan.[7] The number of patients in this study is too small to establish a definite relationship of gold concentration to therapeutic or toxic effects of the drug, but the usefulness of further studies is evident.

Summary

The concentration of gold in the serum and urine was determined in five patients with rheumatoid arthritis receiving chrysotherapy. The serum level of gold tended to reach a plateau of about 150 to 300 micro-

grams per 100 ml. after approximately 75 to 125 mg. of injectable gold had been administered during a period of 21 to 35 days. Toxic manifestations were exhibited in two patients with residual serum gold concentrations above 300 micrograms per 100 ml. of serum. The method of assay used in this study appears to be sufficiently sensitive and precise for estimating gold in serum and urine.

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Effects of Local Gastric Freezing in the Prevention of Mann-Williamson Ulcers in Dogs

Local gastric freezing has been proposed in the treatment of peptic ulcer on the basis that it alters the secretory responses of the stomach (physiological gastrectomy).

Our purpose in this study was to see if pre-operative gastric freezing could prevent the development of the Mann-Williamson ulcer in dogs.

Seven dogs served as control dogs upon which only the Mann-Williamson procedure was performed.

Seven dogs served as test dogs which were subjected to gastric freezing followed in six to 10 days by a Mann-Williamson procedure.

All dogs tolerated the gastric freezing well following which no gross changes were noted in the stomach. Microscopically, we noted a decrease in the volume of mucous secreting cells, evidence of degeneration of the Auerbach's plexus, and decrease in the number of parietal and chief cells.

A third of the test dogs demonstrated insulin resistant achlorhydria.

All the control dogs developed ulcer and died as a result of it. Two of the test dogs died of severe emaciation following the same pattern of weight loss as the control group, but without ulcer. Five died with ulcers; however, their average survival time was 110 days compared to 63 days for the control dogs.

Therefore, gastric freezing prevented the development of the Mann-Williamson ulcer in two of the seven dogs and prolonged the survival time in the other five, probably by delaying the onset of the Mann-Williamson ulcer.

Abstract of paper by J. P. Pagan, M.D. and W. W. Glas, M.D., presented at the Detroit Surgical Association meeting, January 27, 1964.

Neurilemmoma of the Vagus Nerve In the Posterior Mediastinum

Robert C. Moehlig, M.D. and Thadeus L. Jarkowski, M.D.
Detroit, Michigan

ALTHOUGH neurogenic mediastinal tumors are relatively common, such tumors arising from the vagus nerve are extremely rare. In a recent extensive review of the literature,[1] only 13 intrathoracic vagus nerve tumors were noted. Of these, four were neurilemmomas, two of the vagus nerve and two of the recurrent laryngeal nerve. We are reporting a case of neurilemmoma of the vagus nerve in the posterior mediastinum.

Case Report

A 17-year-old male student was admitted to Harper Hospital on June 8, 1962, with a history of recurring tonsillitis. A tonsillectomy and adenoidectomy was performed the day of admission. The admittance photofluorogram disclosed a mass in the right mediastinum. Multiple film projections showed that the mass was in the upper mediastinum just above the level of the aortic arch projecting to the right. It was about 4 cm. in diameter and presented a smooth, rounded right border in the frontal projection, and a smooth superior and posterior border in the lateral projection (Fig. 1). Fluoroscopically, its superior left margin was observed distinctly, and it would appear therefore to have a rounded character in most of its tangents.

During deglutition of barium there was displacement of the esophagus to the left by the mass.

Because of tachycardia, nervousness and a tremor of the fingers, hyperthyroidism was considered. A protein bound iodine was reported as 5 micrograms, and a tracer dose of I^{131} was given and was reported as compatible with normal thyroid function. There was no evidence of thyroid origin in the mediastinal mass. The electrocardiogram was reported as normal. The laryngeal nerves were intact since laryngeal paralysis was not noted.

On July 11, the tumor was removed from the right posterior mediastinum, covered by smooth pleura just above the vagus vein in the line of the vagus nerve. The tumor measured 5 x 4 x 3.5 cm. and its surface was pink and well encapsulated. Many tortuous vessels were noted. Microscopically, numerous cystic areas were noted with an edematous and myxomatous appearance. These cystic Antoni B type arrangements made up the bulk of the tumor. Other areas (Fig. 2) showed palisading of the nuclei, typically the Antoni A type of arrangement. The tumor was well encapsulated.



Fig. 1 *(left)* Roentgenogram showing the solid tumor in the right superior mediastinum with its rounded, smooth edge; *(right)* Lateral view further outlines this tumor.

The patient made a good recovery but immediately developed hoarseness postoperatively because of paralysis of the



ROBERT C. MOEHLIG, M.D.
Author

From the Department of Medicine and Pathology, Harper Hospital, Detroit, Michigan.

right vocal cord. His voice was high pitched, weak and barely audible. Following a two-month course of Methyltestosterone (10 mgs. daily), the voice became deeper and more audible.

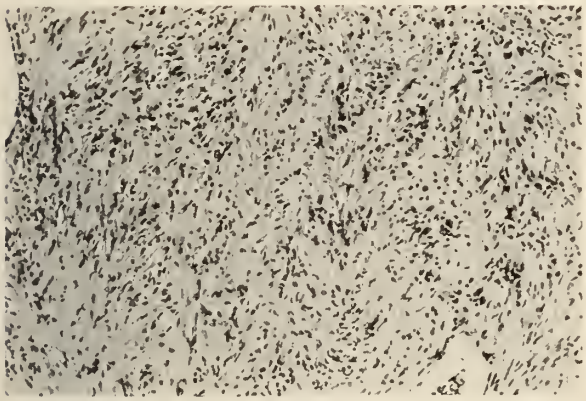


Fig. 2. Photomicrograph showing the palisading of nuclei typical of the Antoni type A arrangement. H & E stain x 88.

Comment

It was fortunate that an admission photofluorogram furnished the clue to the discovery of the mediastinal mass. Although enucleation of the tumor and salvage of the vagus nerve can be attempted, it is very difficult. The tumor is benign but will recur if not completely excised. It has been the experience of others that the neoplasm is so intimate with the vagus nerve that transection of this nerve is necessary. The only major complication encountered thus far to the vagal section was laryngeal palsy. This is particularly true of the neurilemmomas of the neck, as stated by Leichtling.[2] In his two cases, the hoarseness improved, the first after a period of eighteen months and the second had a progressively decreasing hoarseness. Our case displayed excellent compensation of the hoarseness, in all probability aside from the hormone therapy. However, we know that deepening of the voice occurs with the administration of male hormone and is especially noticeable in women. The patient is in excellent health six months post-operatively.

Summary

A case of right-sided mediastinal neurilemmoma of the vagus nerve is reported in a 17-year-old student. The tumor mass was discovered in the routine admission photofluorogram and successfully removed.

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Medical Maxims

When adequate diets have failed, blood protein levels in bedridden patients may be brought up to normal with exercise.

Every effective morphine derivative is capable of producing addiction which parallels the analgesic potency of the particular drug.

Approximately 20 to 25 per cent of patients with hiatus hernia have some degree of associated anemia.

Hysteria attacks only in the presence of an audience.

Aspirin should never be given asthmatics without first inquiring as to sensitivity to this drug.

From "711 Medical Maxims, II"
by WILLIAM S. REVENO, M.D.;
Publisher, Charles C Thomas,
Springfield, Illinois.

IN MEMORIAM

HENRY W. CADIEUX, M.D., 93, who practiced medicine and surgery in Detroit for 64 years prior to his retirement in 1960, died March 28, 1964.

Prior to his retirement he was on the staff of Detroit Memorial Hospital. He was on the consulting staff of St. Mary's Hospital.

Doctor Cadieux was graduated in 1896 from the Detroit College of Medicine, now Wayne State University School of Medicine.

He was a member of the East End Medical Association and a Life Member of the Michigan State Medical Society.

ELISHA W. CASTER, M.D., 84, Detroit area physician for more than half a century, died March 31, 1964.

A graduate of the Detroit College of Medicine, now Wayne State University School of Medicine, Doctor Caster was a co-founder of Highland Park General Hospital in 1921, and a member and past president of its staff.

He was a Life Member of the Michigan State Medical Society.

JOE DePREE, M.D., 74, Grand Rapids physician since World War I, died March 26, 1964.

A graduate of the University of Michigan Medical School, Doctor DePree was a captain in the Medical Corps in World War I. Following his military service he began practice in Grand Rapids where he practiced until his death.

He was a member of the American and Michigan Societies of Anesthesiologists, the International Anesthesia Research Society, the American Physicians Art Association, and the Associated Anesthesiologists of Grand Rapids. He was a Life Member of the Michigan State Medical Society.

EDMOND J. DUROCHER, M.D., 82, Ecorse physician for more than 50 years, died April 5, 1964.

A 1912 graduate of the Detroit College of Medicine, Doctor Durocher was on the staff of Delray General and Outer Drive Hospitals. He was a Life Member of the Michigan State Medical Society.

GERALD O. GRAIN, M.D., 71, Marquette, noted psychiatrist and neurologist, died April 20, 1964.

Doctor Grain retired from Ford Hospital in Detroit in 1957 after 31 years as a consultant in neurology. Following his retirement, he moved to Marquette and became associate staff member of St. Luke's and St. Mary's Hospitals and a consultant in neurology for the Veterans Administration.

He was a 1916 graduate of the University of Manitoba medical school.

CHARLES J. JENTGEN, M.D., 78, medical director of St. John Hospital, Detroit, died April 10, 1964.

A 1911 graduate of the University of Michigan Medical School, Doctor Jentgen began practice in Detroit following military service in World War I.

Doctor Jentgen was on the staff of Providence Hospital for 32 years until his appointment as medical director at St. John Hospital in 1952. He remained an honorary staff member at Providence after moving to St. John Hospital.

In 1963, Doctor Jentgen received the "MSMS Certificate of Commendation" for his contributions to medicine, teaching and medical administration. He was a member of the American Board of Surgery, American College of Surgeons, and a Life Member of the Michigan State Medical Society.

CHARLES S. NORTON, M.D., 84, Detroit physician since 1901, died March 30, 1964.

Formerly a member of the staff of Providence Hospital, Doctor Norton was a member of the first graduating class at Detroit College of Medicine.

He was a Life Member of the Michigan State Medical Society.

HERBERT F. ROBB, M.D., 73, Belleville general practitioner since 1920, died April 4, 1964.

After his graduation from the Detroit College of Medicine in 1916, Doctor Robb served in the army medical corps during World War I, and practiced medicine in Montana for a year before returning to Michigan.

Doctor Robb was a Life Member of the Michigan State Medical Society.

HAROLD B. ROTHBART, M.D., 57, Oak Park pediatrician, died March 22, 1964.

Doctor Rothbart received his medical degree from the University of Toronto in 1930. He practiced in Ann Arbor for six years before coming to the Detroit area. Doctor Rothbart had been on the staffs of Harper, Children's, Beaumont, and Sinai Hospitals. He was a diplomate of the American Board of Pediatrics, and a past president of the Pediatrics Society of Detroit. He taught at University of Michigan and Wayne State University medical schools.

JULIAN J. RUCKER, M.D., 66, Detroit physician since 1926, died March 14, 1964.

Doctor Rucker was a graduate of Meharry Medical College, and attended the University of Michigan and Rochester University. He was a 25-year member of Alpha Phi Alpha fraternity.

Sodium and the Health Department

A State Health Department serves its purposes particularly well and attracts commendation for itself when it fulfills those needs that are difficult or impossible for the individual physician in private practice to meet. The Michigan Department of Health has demonstrated this by its recent distribution of the booklet entitled, "Sodium Content of Public Water Supplies in Michigan." John A. Cowan, M.D., Director of the Division of Adult Health, has underlined the frustrating problem of failure of diuresis that may be due to consumption of water high in sodium and in the booklet lists, in milligrams per liter, the sodium content of communities of Michigan.

Samples of private water supplies not listed in the bulletin can be submitted on a physician's request to the Michigan Department of Health, Division of Laboratories, Lansing, Michigan, to be tested for sodium content and we are told that the listings in the booklet will be updated and supplemented regularly.

Those communities using water softening by the Zeolite method are indicated in the booklet. Their water may contain a significant increment of sodium. While the sodium content of water in most communities is low, all but two of those using the Zeolite process have a sodium content in excess of 100 mgm per liter. East Lansing may reach 223 mgm per liter and Mt. Morris is highest at 415 mgm per liter. Even without the Zeolite effect, sodium levels in the water supply may reach significant levels, as at Akron in Tuscola County where the level is 669 mgm of sodium per liter.

Credit where credit is due, and our thanks to the Michigan Department of Health for fulfilling a service by providing information not otherwise readily available to physicians for use in the treatment of their individual patients.

Welcome, Dean Hunt

On July 1, 1964, Andrew D. Hunt, M.D., will assume the position of Dean of the Program in Human Medicine at Michigan State University. Michigan medicine bids him welcome to the State and to East Lansing.

Doctor Hunt is a native of New York and was awarded the Bachelor of Science degree at Haverford College in

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1937. He received his M.D. degree at Cornell University in 1941 and served an internship and pediatric residency at the University of Pennsylvania Hospital before entering the Army in 1943.

From 1946 to 1952, he taught pediatrics at the University of Pennsylvania and served at the Children's Hospital, Philadelphia, where he became a Director of Clinics. He then directed the pediatrics services at the Hunterdon Medical Center in New Jersey before moving, in 1959, to Stanford University's Medical School where he has served until the present time as Director of the Stanford Ambulatory Service and as Associate Professor of Pediatrics.

The doctors of Michigan have traditionally exhibited a sincere interest in medical education and have given it strong support. We hope that Doctor Hunt will avail himself of their wise counsel and advice for we are sure that he will find them most cooperative.

Radiation Study

The Public Health Service plans to undertake the second of a series of national x-ray studies designed to provide additional information about the x-ray experience of the U. S. population. These studies are being conducted jointly by the Division of Radiological Health and the National Health Survey of the Public Health Service. A report on the first study covering x-ray visits from July, 1960-June, 1961, was published by the National Health Survey in October, 1962.

Many articles and reports have indicated that an important segment of the total radiation to which the population is exposed may be accounted for by medical and dental x-rays. Thus, long-range efforts are being made by appropriate medical and dental organizations and public health agencies throughout the country toward elimination of unnecessary radiation exposure from the healing arts without loss of the diagnostic or therapeutic benefits which x-rays provide.

In attempting to assess the present situation regarding exposure, the Public Health Service study will seek information designed to help the medical and dental professions to make more efficient use of x-ray equipment.

A number of efforts have been made in the past to obtain information about x-ray exposure in this country. These studies have been limited to selected populations or to certain types of examinations. The current study will be comparable in scope to the comprehensive studies made in other countries, including Great Britain.

The current study was planned with the advice of a group of distinguished radiologists and physicists. These consultants had available a report on a field trial conducted in Berks County, Pennsylvania, during the summer of 1963 to determine the feasibility of the methodology to be used in the national study. A vital factor in the success of the field trial was the excellent cooperation of physicians, dentists and other practitioners who were asked to participate. A summary of the feasibility report will appear in the March issue of *Public Health Reports*.

The national study will extend the information published in the National Health Survey Report by providing radiographic, fluoroscopic and therapeutic exposure estimates for a representative sample of the U. S. population. A third study is planned in which these exposure data will be translated into dose estimates to specific body organs. This will be accomplished through continued collaboration with radiologists and physicists engaged in dosimetric research.

The data collection phase of the current study began in April, 1964, with a household interview survey in which x-ray visit information will be obtained for the preceding three-month period. The survey will cover approximately 10,000 households and 32,000 persons. From May through September 1964 follow-up questionnaires and film packs, designed to provide the required exposure information, will be

mailed to practitioners or facilities identified in the household interview survey. It is estimated that approximately 6,000 x-ray facilities will be involved during this period. In each case, authorization to provide the requested information will have been obtained from the household respondent.

The cooperation of all practitioners or facilities receiving follow-up requests is essential to meet the objectives of the study.

All information pertaining to individual patients, practitioners and facilities will be treated confidentially; only statistical summaries will be made available for publication. For further information write to the Division of Radiological Health, Public Health Service, Washington, D.C. 20201.

Responsibility

By Fred Moench, M.D., Director,
Midland County Health Department

Individuals and families make up the community, communities make up cities and counties. These political units form our states which in turn comprise our nation. The health status of the individuals determines the health status of the nation.

Now let us ask, "Who has prime responsibility for a program of continuous health care?" In our democracy, with its four basic freedoms, we find that our laws permit a classification of individual health responsibility and health promotion resources into five major groups:

1) At the head of the list, places responsibility squarely on the individual, parent, or guardian;

2) Commerce and industry which furnish the jobs and products that help the individual provide health supervision for himself and his family (these include food products, clothing, shelter, etc.);

3) Professional and ancillary personnel, rendering medical and hospital care services;

4) Unique in our country are the many voluntary organizations and societies and service clubs, with partial or total interest in health services and health education—organizations of Parents and Teachers Associations is a good example, the Michigan Health Council is another;

5) Our government, with local, state, and national responsibility and resources for continuous health supervision.

It is a generally accepted concept that the privilege of providing for himself and his family belongs to the individual and that society should step in to help only at that point where the individual, for any reason, is unable to provide for himself and his family.

Now with preventative, continuous health supervision, care and treatment recognized as being fundamental, the health of the people depends to a much greater degree upon individual responsibility. It is up to the individual to consult his physician or his public health department for early and continuous health supervision, to avoid obesity and alcoholism, to drive his automobile safely. These acts cannot be performed for him by his government; they require information, skills, and motivation.

Society must assure its citizens access to professional services, education concerning personal health education and reasonably safe environment. The broad view of health supervision and service preserves the patient-physician relationship, not only what the physician does in the diagnosis and treatment of disease, but also includes preventive efforts, promotion of sound health practices and rehabilitation. This concept of comprehensive service must presuppose teamwork comprising a variety of personnel and facilities, with the physician leading the over-all effort.

MSMS Centennial Series—1939

House of Delegates in Special Session Approves Group Medical, Hospital Service

By William J. Stapleton, Jr., M.D.
Detroit, Michigan
MSMS Historian

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

The President of the Michigan State Medical Society for 1938-39 was Henry A. Luce, M.D., Detroit. For many years the writer knew Doctor Luce as a friend, a leader in his chosen specialty, and a true gentleman with a kindly manner toward all. In addition, he was a medical statesman, who all his life worked for the betterment of Michigan State Medical Society and its aims to improve the practice of medicine. The Society owes a great debt to Henry Luce. This year was a busy and important one in medical matters.



Henry A. Luce, M.D.
President 1938-39

Here is a digest of the highlights of the meeting of the Executive Committee held on October 19, 1939:

1. Group Hospitalization Service and Medical Care Plans were studied for presentation to the MSMS House of Delegates.
2. Requisites for Associate Fellowship in Postgraduate Education MSMS were widened.
3. It was reported that automobile license plates for physicians, with M.D. thereon, would be available in 1940.



The Author
WILLIAM J.
STAPLETON, JR., M.D.
MSMS Historian

The Department of Internal Medicine of the University of Michigan inaugurated in 1938 a series of medical conferences, the first of which was held in the Hospital Ampitheatre on October 7.

The 18th Annual Public Health Conference was held at Grand Rapids on November 9-11; the attendance was over 1,200 people.

The mid-year Meeting of the Woman's Auxiliary to the MSMS was held in Detroit on November 18, 1938. A communication came from the MSMS to the effect that, owing to the growth of the Auxiliary, it should finance all of its own activities.

* * *

A SPECIAL MEETING OF the House of Delegates held in Detroit on January 8, 1939, was probably one of the most momentous and important meetings of that legislative body. Two major items came up for consideration: (1) group hospital care and (2) group medical service for those whose income is $1,500 a year or less. The House of Delegates approved both these plans.

The delegates, generally, felt that group hospitalization would allow a subscriber to purchase a given number of days of hospital service for a moderate premium payment, and that medical service would enable a person to purchase units of medical service, such units to include all services rendered by doctors of medicine in all the specialties. The action of the House of Delegates called upon The Council to develop its plans in cooperation with the Michigan Hospital Association, labor, industry, agriculture, and religious and educational groups.

The annual Beaumont Foundation Lectures, under

(Continued on Page 450)



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Research in the Service of Medicine

Say you saw it in the Journal of the Michigan State Medical Society

(Continued from Page 448)

the auspices of the Wayne County Medical Society, on February 20 and 21, 1939, were given by Jesse G. M. Bullowa, M.D., of New York.

The Michigan Association of Industrial Physicians and Surgeons held its annual meeting in Lansing, April 19, 1939.

* * *

THE ANNUAL SECRETARIES' Conference was held in Lansing, January 15. The following were the topics discussed: Michigan's Group Hospitalization and Medical Service Plans, Our Legislative Forecast, and Physicians in the Press and on the Air. The Upper Peninsula Secretaries' Conference was held in Marquette on March 26, 1939.

The Upper Peninsula Medical Society held its annual meeting August 23-24 in Escanaba.

The Executive Committee of The Council meeting in Detroit on May 7, 1939, took the following action:

1. Incorporation of "Medical Security, Inc.," authorized in accordance with Michigan's new voluntary group medical care enabling act the first of its kind in the United States.
2. New postgraduate program in venereal diseases was outlined.
3. Representatives of the MSMS were chosen to serve on the Board of Directors of the Michigan Society for Group Hospitalization.

The Executive Committee of The Council in Detroit on June 22, 1939, approved Articles of Incorporation of the "Michigan Medical Service" covering the MSMS voluntary group medical care plan for submission to the Michigan Insurance Commission.

* * *

THE ANNUAL MEETING was held in Grand Rapids, September 19-22. The program included a four-day intensive postgraduate conference presenting 74 outstanding speakers and over a hundred scientific exhibits. Registration totaled 1,810.

The Cass County Board of Supervisors voted on October to establish a full-time county health department, thus becoming the 61st Michigan County to provide this service.

An impending epidemic of infantile paralysis in the state gave rise to the development of the Michigan Poliomyelitis Commission. This emergency organization was formed to furnish consultation service for the early diagnosis and prompt orthopedic care of poliomyelitis. It was developed through the sponsorship of the MSMS, the Michigan Branch of the American Academy of Pediatrics, the Michigan Department of Health, and the interested lay groups.

* * *

THE MICHIGAN SOCIETY for Group Hospitalization, organized by the Michigan State Hospital Association approved by the MSMS, began its operations in the field of hospital service. The organization provided 21 days of hospital service in any one year. The hospital service included no professional services rendered by a doctor of medicine. It covered room and board, general nursing, operating room and intern service, ordinary drugs and dressings, and certain technical services rendered by hospital employees.

The Executive Committee of The Council, meeting in Lansing on April 16, 1939, took action to oppose the Wagner Bill, and to oppose the transfer of the administration of the Afflicted Child from the Crippled Children's Commission to the Welfare Departments.

The membership for 1938 was 4,205, a gain of 242 members over 1937.

As one looks over the work of the Society, the year 1939 was one of many important matters, not only to the Michigan State Medical Society but to the public at large.

Occupational Medicine Booklet Available

Available from Superintendent of Documents, Government Printing Office, Washington, D. C. 20402:

"Man, Medicine, and Work, Historic Events in Occupational Medicine."

A pictorial study of historic events in occupational medicine from prehistoric times to the present. It covers the development of occupational medicine from Egypt to Rome, during the Middle Ages, from the Renaissance to the Modern state, from the technology in 18th and 19th centuries to the impact of industrialism, and during the transition to automatic mass society. 1963. 52 pages. Illustrated Catalog No. FS 2.2: Oc 1/11. Price 40 cents.

Legislature Adopts Bills Recommended by MSMS

While issues like apportionment have captured the headlines, the Michigan lawmakers have wrestled with nearly 100 bills of direct interest to Medicine.

No bill has been passed, nor existing law changed, which would be a detriment to the health care of the people of Michigan or to the practice of medicine.

Passage of the two-fee schedule bills, the M.A.A. and the O.A.A. improvements, the health insurance "pooling" bill, an improved chemical test law, and many other pieces of legislation, have made 1964 an extremely successful legislative year.

The State Legislature has passed the four bills which stood at the top of the MSMS priority list for 1964. All consideration of medical legislation is now completed.

* * *

KEY BILLS PASSED:

Two bills, passed May 3 and effective July 1, 1964, will eliminate the old top fee and thus the fee schedule and codes of the Michigan Crippled Children Commission. Physicians and surgeons will henceforth be paid 80 per cent of the Michigan Uniform Fee Schedule for Governmental Welfare Agencies, 1959 revision.

The Crippled Children Commission in the future will use the Uniform Fee Schedule and its codes. Physicians should therefore bill according to the Uniform Fee Schedule code and its dollar amount listed—the Commission will reimburse at 80 per cent of that amount.

Top fees thus rise from a former $90.00 to $240.00 representing the first substantial improvement in the schedule since 1947 and culminating a four-year project by MSMS.

Applicants for the M.A.A. program may now earn up to $1,900 per year single (was $1,500), and up to $2,700 per year if married and living together (was $2,500) and still qualify for benefits. This substantial improvement to the Medical Assistance to the Aged program is estimated to make over 11,000 additional medically indigent persons eligible for aid.

MSMS has long urged raising of the income limits, and feels that Michigan's implementation of the Kerr-Mills federal law has been definitely strengthened.

The Old Age Assistance program for elderly persons who are hospitalized or in convalescent homes has been greatly improved. Cash grants to such persons have formerly been fixed at not to exceed $90.00 per month. These grants have now been increased to up to $140.00 per month.

Major legislation enacted as requested by MSMS includes a bill



to permit "pooling" of risks by health insurance companies; "battered child" legislation incorporating desired immunity from liability for physicians; expansion of allowable tests for intoxication as endorsed by MSMS; a law requiring prescription for purchase of paregoric but permitting telephone prescribing; and a law protecting the confidential nature of data submitted to the Health Commissioner for research purposes.

The 96 major health-related proposals before this session of the State Legislature may be classified into several categories of priority. Several bills were introduced relating to the same subject—in which case MSMS sought passage of the best proposal; many proposals introduced were opposed as not in the best health interests of the people; some bills were introduced which MSMS supported as supplementary to its own legislative program.

* * *

THE FOLLOWING LEGISLATIVE proposals were considered by MSMS to *not* be in the best health interests of the public and were successfully opposed:

A redefinition (and major expansion of practice privilege) of chiropractic;

A bill which would have eliminated the right of medical staffs to determine practice privileges in hospitals;

A bill which would have eliminated the right of the medical advisory committee in certain hospitals to recommend professional standards to its lay board;

A bill which would have eliminated the "ability to pay" clause from the 1963 Community Mental Health Services Act;

A bill which would have required all health and accident insurance carriers to pay chiropractors for any services "legally" rendered under the chiropractic license law;

A bill to require a plebiscite before fluoridation of water supplies; and many others, including a proposal to require a lay majority on the Blue Shield Board; to permit psychologists to practice psychotherapy; to create a cancer quackery advisory committee to the State Health Commissioner with a chiropractic advisor member; a number of unsatisfactory versions of chemical test; paregoric prescription, and "battered child" bills; undesirable amendments to the Workmen's Compensation Act; and a bill to license and regulate the practice of hypnosis.

The State Legislature *added nurses* to coverage under the 1963 "Good Samaritan" Law, although

Recent reports suggest... insulin and sulfonylureas may accelerate lipogenesis,[1-5]... serum "insulin" levels are often elevated in obese diabetics[2,3,6]... DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

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In the obese diabetic (ketoacidosis-resistant), DBI (phenformin HCl) with a proper diet: **A.** acts to reduce high blood sugar without increasing fat synthesis or weight gain. **B.** does not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal levels. **C.** favors reduction of weight.

In the ketoacidosis-resistant obese diabetic not amenable to diet alone, hypoglycemic DBI (phenformin HCl) appears to help avoid weight gain or reduce adiposity, factors which otherwise tend to make blood sugar control more difficult and to increase the likelihood of complications. However, in the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic agent.

Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

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MSMS testified that this was not a necessary action, there being no legal "nurse-patient" relationship similar to the doctor-patient relationship. The Legislature also passed one amendment to the Workmen's Compensation Law which, under certain conditions, would make heart and lung diseases compensable. Two proposals were introduced and the one which passed was preferred by MSMS.

* * *

A PROPOSAL introduced for purposes of reorganizing state government into twenty "principal Departments" was introduced, passed the State Senate, but failed to pass the House of Representatives. This proposal, as it passed the Senate, would *not* have provided for a board or commission to head the new and expanded Department of Health, as requested by the Michigan State Medical Society.

The State Legislature, under the new constitution, has next session (1965) to complete this task. If it fails to do so, the Governor has authority to act during the following year. MSMS will continue to closely follow developments in this vitally important area.

No legislation inimical to the best health interests of the people of Michigan has been passed.

Much desirable legislation, endorsed and sought by MSMS, has been enacted into law.

Much undesirable legislation has been rejected by a thoughtful Legislature, which has given MSMS every opportunity to express its views.

Some bills, sought by MSMS, failed this year:

Repeal of the 1937 Basic Science Act; despite a joint statement of support for repeal issued by MSMS and the Michigan Association of Osteopathic Physicians and Surgeons, a suitable vehicle could not be found to legally accomplish this during the present session. Definite progress made toward acceptance of repeal.

Declaring that the transfusion of blood is the performance of a service rather than the sale of a product; some progress made toward establishment of this principle.

The Legal Affairs Committee acknowledges with appreciation the work of the Legislative Agent and the MSMS staff during this complex session. Further, many delegations from County Medical Societies sent helpful delegations to Lansing, and on several occasions the membership-at-large rendered invaluable assistance to the Committee. Several individual physicians sacrificed of their time and gave of their knowledge in testifying before House and Senate Committees. Without the outstanding support which the Committee receives from the members of the Society a



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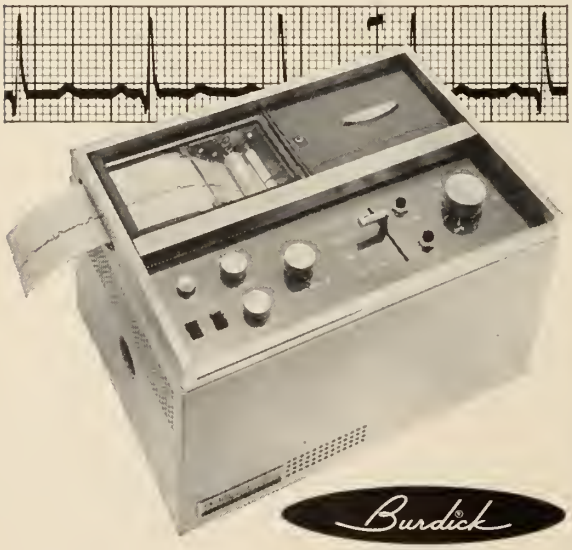
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successful legislative program such as the one just concluded would be impossible.

MAA Rule Change Becomes Effective on July 1, 1964

Commencing July 1, 1964, county welfare departments will be free to negotiate doctor (and hospital) rates separate from the rates paid in other state assistance programs.

This will be made possible by the repeal on that date of Administrative Rule 10, adopted by the State Department of Social Welfare at the onset of the MAA program, and providing that payments for services rendered under Medical Assistance to the Aged could not exceed payments made for similar services under other existing programs.

Rule 10 imposed a restriction which had resulted in the reimbursement of physicians and hospitals at levels equal to those for welfare services. In Wayne County this amounted to approximately 80 per cent of both hospital per diem cost and of the Michigan Uniform Fee Schedule for Governmental Welfare Agencies.

The effect of the Rule was to impose a financial burden upon the hospitals, which were hard pressed to accept MAA cases. As a further effect, physicians were finding it increasingly difficult to place their MAA patients in hospitals of the patients' choice, and to maintain their physician-patient relationship.

As a result of Rule 10's repeal on July 1, it is variously estimated that hospital reimbursements can now be negotiated upward approximately $320,000 per year, the difference between 80 per cent and 100 per cent of per diem cost, thus enabling the hospitals to accept MAA cases without financial hardship. The rule repeal will likewise permit negotiation of doctor's fees up to the full Uniform Fee Schedule, resulting in an aggregate increase in payments to physicians of approximately $225,000 per year.

Seeing MAA costs are borne 50 per cent by federal funds, 40 per cent by state funds, and 10 per cent by county funds, those counties which do not already pay physicians the full Uniform Fee Schedule and hospitals their daily cost (and most counties do) need only defray 10 per cent of the increased funds required to do so. In the case of Wayne County this will probably not exceed $70,000 per year.

The real beneficiaries will be the elderly who are qualified to receive Medical Assistance to the Aged, and who will be able to be placed in the hospitals of their choice, by the physicians of their choice.

Repeal of Rule 10 culminates a two-year intensive campaign, sparked by Wayne County physicians under the leadership of Wyman C. C. Cole, Sr., now President of the Wayne County Medical Society, and assisted by the MSMS Socio-Economic Committee, Legal Affairs Committee and headquarters staff.

Say you saw it in the Journal of the Michigan State Medical Society

U-M Begins Planning Mott Children's Hospital

"Planning of the Charles Stewart Mott Children's Hospital and construction will proceed as rapidly as possible," report the officials of the University of Michigan, who in April received a grant from the Mott Foundation for such a children's hospital.

C. S. Mott, president of the Mott Foundation, has declared "our Board of Trust agreed to furnish the University with funds to build the Children's Hospital in Ann Arbor with belief that this will not only fill the very important medical education need of the University, but also cement the relationship between children's health work at Flint and Ann Arbor."

U-M Dean William N. Hubbard, Jr., M.D., reports "The Mott hospital will be the heart of a new complex devoted to child health. It will replace the antiquated children's wards in the University Hospital that was designed almost 50 years ago. It will provide a facility where children can be cared for in a pleasant, comfortable atmosphere and will be an ideal setting for pediatric education and research."

Patients will be referred to one children's hospital by their own physicans for the treatment of out-of-the-ordinary diseases and injuries, as is the case with University Hospital.

The $6 million Mott grant is one of the largest contributions in the 47-year history of The University of Michigan and ranks with the William W. Cook gift for the Law School, the Horace Rackham grant for the Graduate School, and Ford Motor Company and Ford Fund gift for the Dearborn campus.

The gift of the new hospital is an extension of the Mott Foundation's long interest in the University. Since 1946, the Foundation has been providing medical scholarships and in the last decade fellowships in dentistry.

* * *

Invite Auxiliary to Aid In Mental Health Survey

Mrs. W. S. Wille, Mental Health Chairman for the Woman's Auxiliary, presented a request from the Mental Health Advisory Council to the Mid-Year Board meeting of the Auxiliary for volunteer assistance by Auxiliary members.

This request comes from the Department of Mental Health officials as they plan to implement their part of a State Resource Development Planning Program for Michigan. They are 1 of 10 major state departments involved in the study. In mental health, a Planning Division has been established, a technical advisory committee and a task force committee for each of the following: mental health statutes,



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manpower resources, in-patient psychiatric services, elderly and mentally frail, mental retardation, community mental health services, research and emotionally disturbed children. As progress is made, local planning committees will be established.

Auxiliary volunteers will be requested on the local level for administrative assistance. This might involve assisting the chairman and committee members in the operation of the meetings, seeing that minutes, materials, etc., were in order. Those volunteers that have special interests and skills would be very valuable in assisting task force and planning committees in research and the collation of materials and reports.

At the meeting in Detroit, the Auxiliary expressed its willingness to make volunteers available for this project.

Doctor Anderson Replaces Doctor Anderson!

Doctor Anderson has resigned as Chief of the Biologics Products Section of the Division of Laboratories and has been succeeded by Doctor Anderson!

After 22 years with the Michigan Department of Health, Harlan D. Anderson, Ph.D., has resigned to accept a job with a commercial pharmaceutical firm. George R. Anderson, D.V.M., formerly in charge, since 1961, of the Viral Vaccines Unit of the Biologic Products Section, has been appointed as Chief of the Section. He received his D.V.M. degree from Ohio State University in 1950. The following year, he earned his M.P.H. degree from the School of Public Health, University of Michigan. From 1951 to 1961, he was with the Ohio Health Department.

In his position as Chief of the Biologic Products Section of the Division of Laboratories, Doctor Anderson will be responsible for the production of blood fractions, vaccines, and serums distributed to physicians throughout the state.

State Narcotic License Renewable Before July 1

The Michigan Board of Pharmacy has this year changed the method for renewal of all licenses issued by this board which includes the Michigan Narcotic License. All applications and licenses will be processed by electronic data processing, the renewal applications for all physicians and other members of the healing arts were released from that office the latter part of April.

The Board had asked cooperation of all registrants with the board to make the necessary corrections as to change of address, professional license number and

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any other pertinent information, in the return envelope application which was mailed with the application.

The narcotic license is renewable on or before July 1. A state narcotic license under the Michigan uniform narcotic act is a prerequisite to a federal narcotic permit.

Any questions should be directed to Michigan Board of Pharmacy, 115 Stevens T. Mason Building, Lansing.

MAP Adds Lansing TV Program about Professions

The Michigan Association of the Professions has launched a new weekly television show over WJIM-TV, Channel 6, Lansing. Entitled "Formula," this half-hour program is patterned after MAP's program "Decisions," which recently completed its third year over Channel 2, Detroit.

The basic idea of the program is that there is a "formula" for everything—progress, success, freedom, health, even love. Opinions differ as to what these formulas are, thus providing for a clash of opinion. There are even sub-formulas, various methods for arriving at important decisions, and interesting materials and means used to implement professional judgments.

Helen Menton, Executive Assistant of MAP, will produce the program. The series came from the desire of Harold Gross of East Lansing, owner and manager of WJIM, to make his station an even greater source of information to the people. "Formula" will feature the same host, Hugh W. Brenneman, executive director of the MSMS and MAP.

Thoracic Society Installs Isbister; Elects Nedwicki

John L. Isbister, M.D., Lansing, is the new president of the Michigan Thoracic Society, installed at a spring session of the Society in Ann Arbor.

Edward G. Nedwicki, M.D., Dearborn, is the new president-elect.

Other officers elected were: Robert A. Green, M.D., Ann Arbor, secretary-treasurer; and Wilbur J. Steininger, Jr., M.D., representative councilor to the American Thoracic Society.

WM General Practice Chapter Installs Officers

Robert Claytor, M.D., Grand Rapids, recently was chosen President-Elect of the West Michigan Chapter of the American Academy of General Practice.

At the same meeting, Dick R. Mouw, M.D., Grand

Rapids, was installed as the new president to succeed G. Edward Braunschneider, M.D., Grand Rapids.

Other officers, all from Grand Rapids, include vice president, John Vandermolen, M.D.; secretary-treasurer, Bernard Kool, M.D.; and directors, Virgil E. Stover, M.D., and Erwin Fitzgerald, M.D., and Arthur J. Tesseine, M.D.

Saltonstall Re-Elected An Officer of MAP

G. B. Saltonstall, M.D., a past-president of MSMS from Charlevoix, has been re-elected treasurer of the Michigan Association of the Professions.

The MAP leadership team for the coming year includes Henry L. Homan, D.D.S., Grand Rapids, president; Adrian N. Lanqius, F.A.I.A., Lansing, vice president and Edwin H. Young, P.E., Ann Arbor, secretary.

Along with Doctor Saltonstall, MSMS is represented on the board of directors by Luther R. Leader, M.D., Bloomfield Hills, and D. Bruce Wiley, M.D., Utica.

Cancer Foundation Offers Film for Men

The Michigan Cancer Foundation's new film for men, "Time for Living," was lauded at the Foundation's Crusade Kickoff Luncheon.

U. S. Rep. John E. Fogarty, Rhode Island Republican, paid tribute to the more than 16,000 Foundation volunteers who conduct a program of public and professional education, support research, and give service to cancer patients in four Southeastern counties of the state.

Oscar D. Stryker, M.D., Macomb County Health Commissioner, is president of the Foundation.

State Medical Writers Continue Same Officers

Officers of the Michigan Chapter of the American Medical Writers Association have been re-elected for another year. Renamed at the recent annual state meeting at Ann Arbor were C. Howard Ross, M.D., Ann Arbor, President; Hazen L. Miller, M.D., Birmingham, Vice President, and Charles W. Sellers, M.D., Detroit, Secretary.

MSMS members who spoke at the Ann Arbor meeting were W. N. Hubbard, M.D.; C. J. Tupper, M.D.; C. Howard Ross, M.D.; W. S. Smith, M.D.; E. F. Wolfman, M.D., all of Ann Arbor; Orlen J. Johnson, M.D., Bay City; Lyle Korum, M.D.; E. Clarkson Long, M.D.; F. P. Rhoades, M.D.; Charles W. Sellers, M.D.; Alfred H. Whittaker, M.D., all of Detroit; and Prof. James Stokley of East Lansing.

Also participating were Harlan Hatcher, Ph.D., Ann Arbor; Gordon Scott, Ph.D., Detroit; and Herbert A. Auer, East Lansing.

Coller-Penberthy Conference To Spotlight Sen. Millikin

One of the highlights at the 44th annual Coller-Penberthy Medical Conference at Traverse City, July 30-31, will be the banquet address July 30, by State Senator William G. Millikin of Traverse City. Frederick A. Coller, M.D., will preside at the banquet, at the Park Place Motor Inn.

An outstanding program of scientific speakers has been arranged and will be reported in the July Journal. There also will be a golf tourament and other recreational activities.

Frank H. Power, M.D., Traverse City, is the general chairman.

Osteopaths

From "Statistics," Annual Report of the Osteopathic Profession, 1963

The 1963 American Osteopathic Association Yearbook and Directory lists 12,109 Doctors of Osteopathy living in the United States. Of these, 97.8 per cent are located in the 39 states and the District of Columbia where DOs may qualify for licensure as physicians and surgeons without restriction. Only 1.6 per cent of DOs are located in six states which limit the use of drugs and permit only minor surgery. Only .6 per cent of DOs are located in four states where licensing laws prevent the use of all drugs and surgery.

Michigan, with 1,717 DOs has the largest number of osteopathic physicians of any state. Other most populated states are Pennsylvania, 1,442; Missouri, 1,126; Ohio, 933; Texas, 741; California, 532; New Jersey, 524; New York, 523; and Florida, 521. Some 49.2 per cent of DOs are located in communities of less than 50,000 population while 22.1 per cent are located in communities of less than 5,000 population.

Of all DOs in private practice some 59.3 per cent are general practitioners; 18.2 per cent are general practitioners giving particular attention to a specialty; 10.4 per cent limit their practice to a specialty while 12.1 per cent limit their practice to manipulative therapy.

General surgery is the largest medical specialty within the osteopathic profession with 533 DOs devoting full- or part-time to the specialty. Other leading specialties are proctology, 378; internal medicine, 289, obstetrics-gynecology, 270; and anesthesiology, 251.

The median age of DOs in private practice is 47.4 years.

During the past 10 years, osteopathic colleges have graduated 4,385 new Doctors of Osteopathy.

—*Public Health Economics*, Vol. 21, No. 2, Feb. 1964.

Brief and to the Point

A new member of the State Corrections Commission, appointed by Governor Romney, is **Duane L. Waters, M.D.**, Manistique. He fills the vacancy caused by the death of J. W. Rice, publisher of the Daily Mining Gazette of Houghton.

The Junior League of Detroit recently honored 50 Detroit citizens at a community luncheon, including **Frank J. Sladen, M.D.**, Detroit, cited for giving "much time as a board member in medical service, education and referral to the members of the Senior Center."

The Lenawee County Civil War Round Table saw an illustrated lecture by **Richard D. Mudd, M.D.**, Saginaw, grandson of Samuel A. Mudd, M.D., who set the leg fracture of John Wilkes Booth.

The Grand Rapids Press carried a recent feature article about **L. D. Funk, M.D.**, Athens, recalling his enjoyment in racing horses at Chicago, Detroit and other tracks.

"Rotarian of the Year" for the Kalamazoo South Rotary Club is **Raymond O. Swann, M.D.**, Portage, who was named for his "continuing activities in behalf of his community."

The new treasurer of the Industrial Medical Association is **Duane L. Block, M.D.**, who is in charge of the Rouge Medical Service of the Ford Motor Company.

The new Commissioner of Health for Broome County, Binghamton, New York, is **Cameron F. McRae, M.D.**, until recently deputy director of the Macomb County Health Department.

Featured speaker at the Wayne State University Annual Law Day Program was **Elliot D. Luby, M.D.**, Detroit. He discussed "Murder with Malice—from Dostoyevsky to Dallas."

John R. G. Gosling, M.D., associated professor of obstetrics and gynecology, is now an assistant dean of the University of Michigan school of medicine, replacing Earl F. Wolfman, Jr., M.D., present associate professor of surgery.

The topic, "What the Schools Can Do for the Community" was discussed by **Louis F. May, M.D.**, Howell, in a program for the Fowlerville PTA.

The work of SS HOPE was described for the Barry-Calhoun District Nurses Association by three Battle Creek doctors who have served on the HOPE Ship—**Charles E. Parkinson, M.D., Stuart P. Barden, M.D.**, and **Charles J. Ryan, M.D.**



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A Distinguished Service Award was presented at the recent convention of the Michigan Congress of Parents and Teachers to **Johan W. Eliot, M.D.**, Ann Arbor, for his service to the PTA Health Committee.

Assistant Dean is the new title at Wayne State University School of Medicine for **Alexander J. Walt, M.D.**, as associate professor of surgery. He replaces **Harrison Sadler, M.D.**, who continues in the undergraduate teaching program.

The Michigan Nurses Association Spring Conference at MSU heard **Lawrence Drolett, M.D.**, Lansing, discuss "Legal Implications in Delegating Responsibilities."

Serving on the Clinton County Arrangements Committee for a Regional Conference of the Michigan Society of Gerontology was **Paul F. Stoller, M.D.**, of St. Johns.

Information about epilepsy was presented by **John R. Williams, M.D.**, Grand Rapids, on a Michigan Health Council television program over WZZM-TV, Channel 13, Grand Rapids.

A senior at the University of Michigan Medical School, **John F. Selden,** was one of 10 outstanding medical students to be awarded a SAMA-Sears Preceptor Scholarship. He will spend two months working with Roger S. Roof, M.D., at Spencer, Indiana.

A talk about "Bridging the Gap between Science and the Layman" was given by **Donald D. Finlayson, M.D.**, to the American Association of University Women at Sault Ste. Marie.

Speaking to the New Trier High School, near Chicago, was **Ralph S. Green, M.D.**, Oak Park, on "Emotional Problems of the Teen-ager—Their Causes and Treatment."

William L. Shields, M.D., has retired from the Chrysler Corporation medical staff after 31 years of service.

The relationships between lung cancer and tobacco smoking were traced for the Escanaba Kiwanis Club by **James Gordon, M.D.**, Escanaba.

Congregation Beth Abraham, Detroit, recently honored **Max K. Newman, M.D.**, Detroit, and his brother, Harry Newman, Detroit dentist, at a testimonial dinner.

Grants have been received by Wayne State University from the U. S. Public Health Service



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for $47,158 for skin research conducted by **Herman K. B. Pinkus, M.D.,** Monroe; and $83,884 for a training program in radiological health to be directed by **James E. Lofstrom, M.D.,** Detroit.

H. John Kitto, M.D., is chairman of the medical advisory committee to the new Flint Community Planned Parenthood Association Birth Control Center that will open June 1.

Coming in July

Next month's issue of the JMSMS will appear under the new title of MICHIGAN MEDICINE and will feature a number of changes in format.

The scientific articles will cover a range of topics including Dean Gardner's views on The University and The Medical Center. Also included are articles on Child Psychiatry, Diagnosis of Aortic Dissection, Cholelithiasis in the Young Woman, and others.

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The Doctor's Library

Books received by THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY *are acknowledged in this column. Selections will be made for more extensive review in the interest of readers as space permits.*

HANDBOOK OF OCULAR THERAPEUTICS AND PHARMACOLOGY. By Philip P. Ellis, M.D., and Donn L. Smith, Ph.D., M.D. St. Louis, Mo.: The C. V. Mosby Company, 1963. Price $8.50.

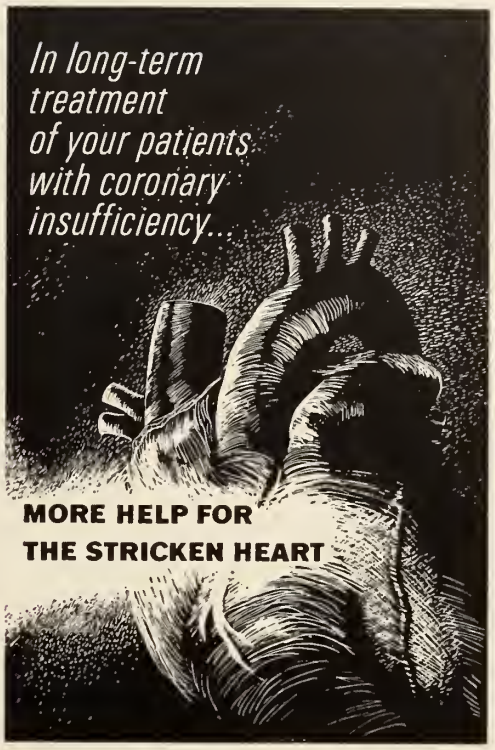
The subject matter of the handbook is divided into two sections which may be briefly explored.

The first section deals with some basic considerations of ocular therapeutics and then outlines medical therapy for the various ocular disorders grouped under the usual anatomic headings of cornea, eyelids, uveal tract, etc. The chapter on steroids contains a useful tabulation of the available drugs with a listing of generic names, trade names, relative dosages, and available strengths. The chapter on principles of antibiotic therapy likewise has a helpful reference table listing the various chemotherapeutic and antibiotic agents available with systemic and topical dosage schedules. The chapters on therapy of glaucoma and uveitis are not sufficiently detailed to be of much help to the practicing ophthalmologist. However, this cannot be held a valid criticism since in the preface the authors clearly renounce any claim to being comprehensive in their therapeutic descriptions. Conversely, the chapter on therapy of intraocular infections is loaded with pertinent clinical material and should have some value for even the most astute clinician.

The second section of the book consists of an alphabetical listing of the various drugs used by the ophthalmologist in the different facets of his practice. Each drug is briefly described as to its actions, ophthalmic uses, side reactions and contraindications, preparations, and dosage. Eighty-seven drugs are included and the selection is most adequate although every reader will probably find an occasional inclusion or omission with which to quarrel.

In general the handbook should find its most receptive audience in the ophthalmologic resident groups for whom it will serve as a trunk from which to branch out into the voluminous contemporary literature on ocular therapeutics. The generalist or pediatrician who prefers to treat the most common eye lesions himself will find useful material in the chapters on extraocular disorders. The clinical ophthalmologist will benefit when a certain name, preparation, dosage, or seldom used form of therapy momentarily escapes his cluttered mind.

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- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

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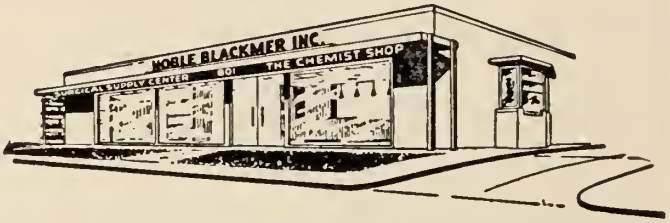
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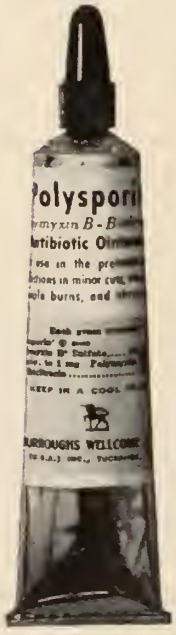
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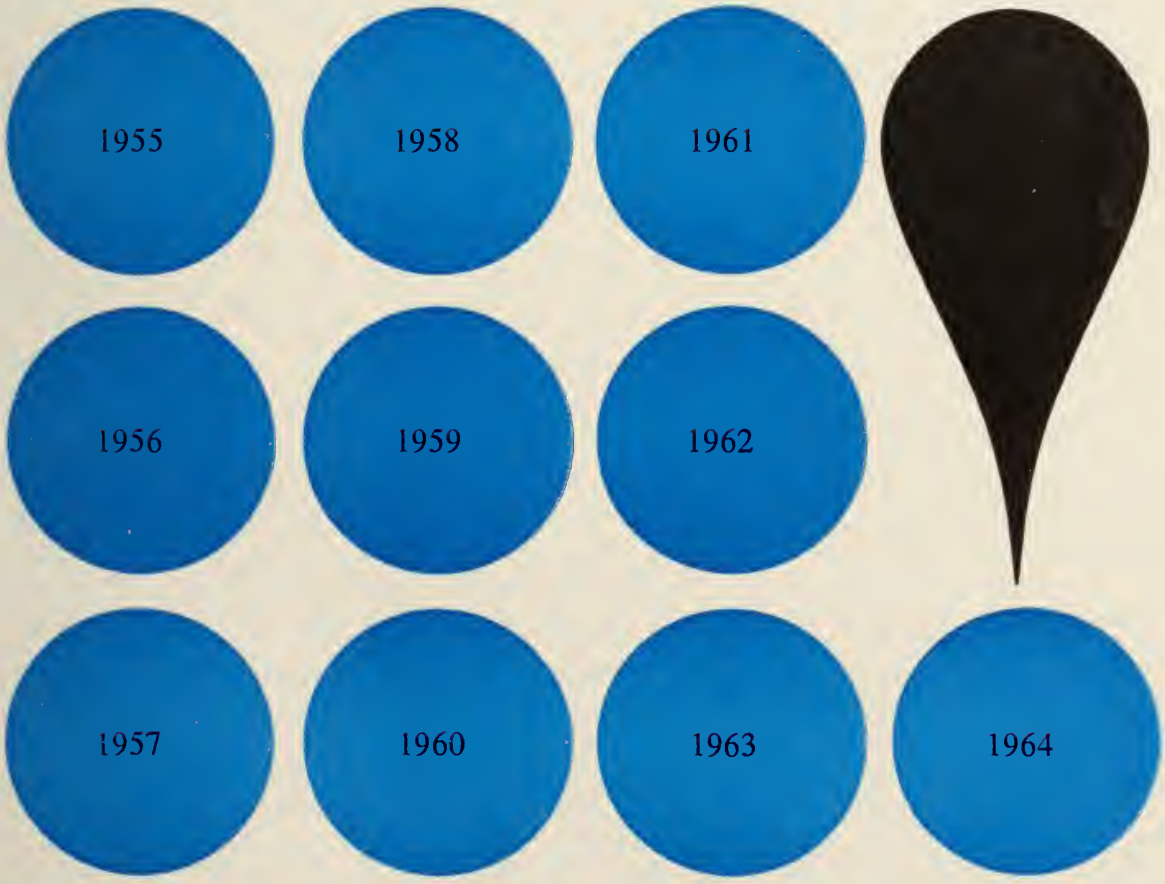
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MICHIGAN MEDICINE

the journal of the michigan state medical society

JULY 1964 • VOL. 63 • NO. 7

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All communications regarding advertising and subscriptions should be addressed to Hugh W. Brenneman, 120 W. Saginaw Street, East Lansing, Michigan. Telephone 337-1351 (Area Code 517).

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President's Message

"New" Journal At Your Service

By Orlen J. Johnson, M.D.
MSMS President

The Journal looks different?

Yes! And that's because it is different.

MICHIGAN MEDICINE, the Journal of the Michigan State Medical Society, has been redesigned to increase its readability and its value to you.



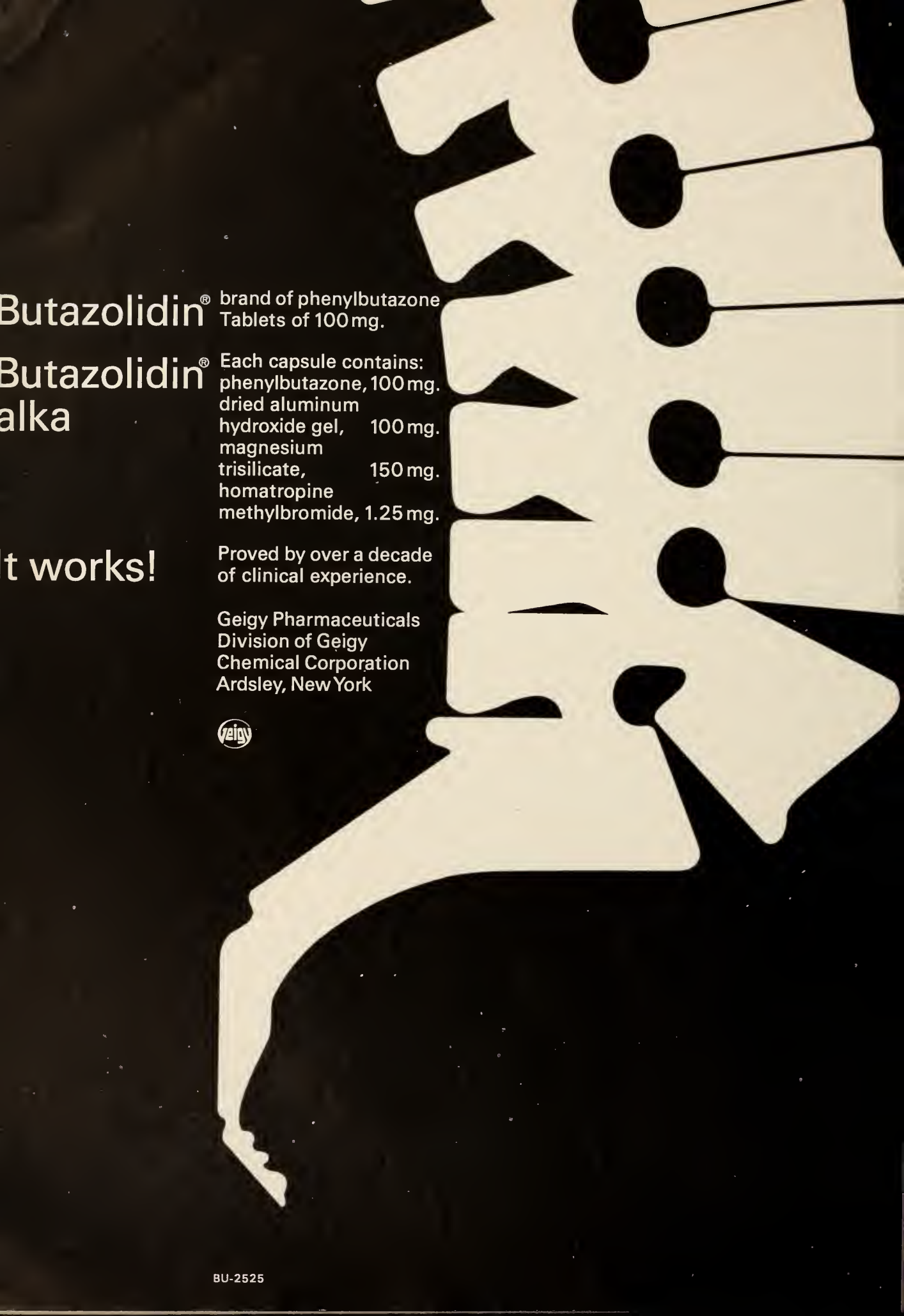
After considerable research, the publication has been changed to improve its contents and appearance. The Publication Committee recommended 14 specific changes in the Journal, and these have been enthusiastically approved by The Council.

Throughout the publication, you will find a more readable type face, new headline styles, new art symbols and new features.

Certainly, one of the major changes is the insertion of four "hot news" pages in the center of the publication. Each month, you will be able to read the colored pages and be right up to date on events of importance. Following this Journal, which will leave the printers on the first of each month, will be a 4-page or 8-page newsletter to each member on the 15th of each month. So instead of MSMS material reaching you only once a month, the staff will hustle to provide fast communication with you twice each month.

The new Journal will include more news about legislation, and the former "Legislative Report," which went only to a limited mailing list during the legislative session, now will be included in the Journal for each of you. We note a growing interest among all members in legislative matters.

We welcome your suggestions and comments to further improve MICHIGAN MEDICINE as we strive more effectively to serve each MSMS member, and to improve the health of the general public.


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GENERAL INFORMATION:

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. A copy is sent to each member of the Society.

Notice of change of address should be sent promptly to the Michigan State Medical Society, P.O. Box 152, East Lansing, Michigan.

Members are invited to submit to the Journal any suggestions for the welfare of the Society, as well as comments or criticisms of any material in the Journal. All such communications should be directed to the Publication Committee of the Journal. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted to it.

ADVICE TO AUTHORS:

1. Address scientific manuscripts to Editor, MICHIGAN MEDICINE, C. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.

2. Submit original, double-spaced, typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by the Journal. The Journal will pay the first $25 of the engraving bill, and the author shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.

7. Contributors will be notified as soon as practicable if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in MICHIGAN MEDICINE.



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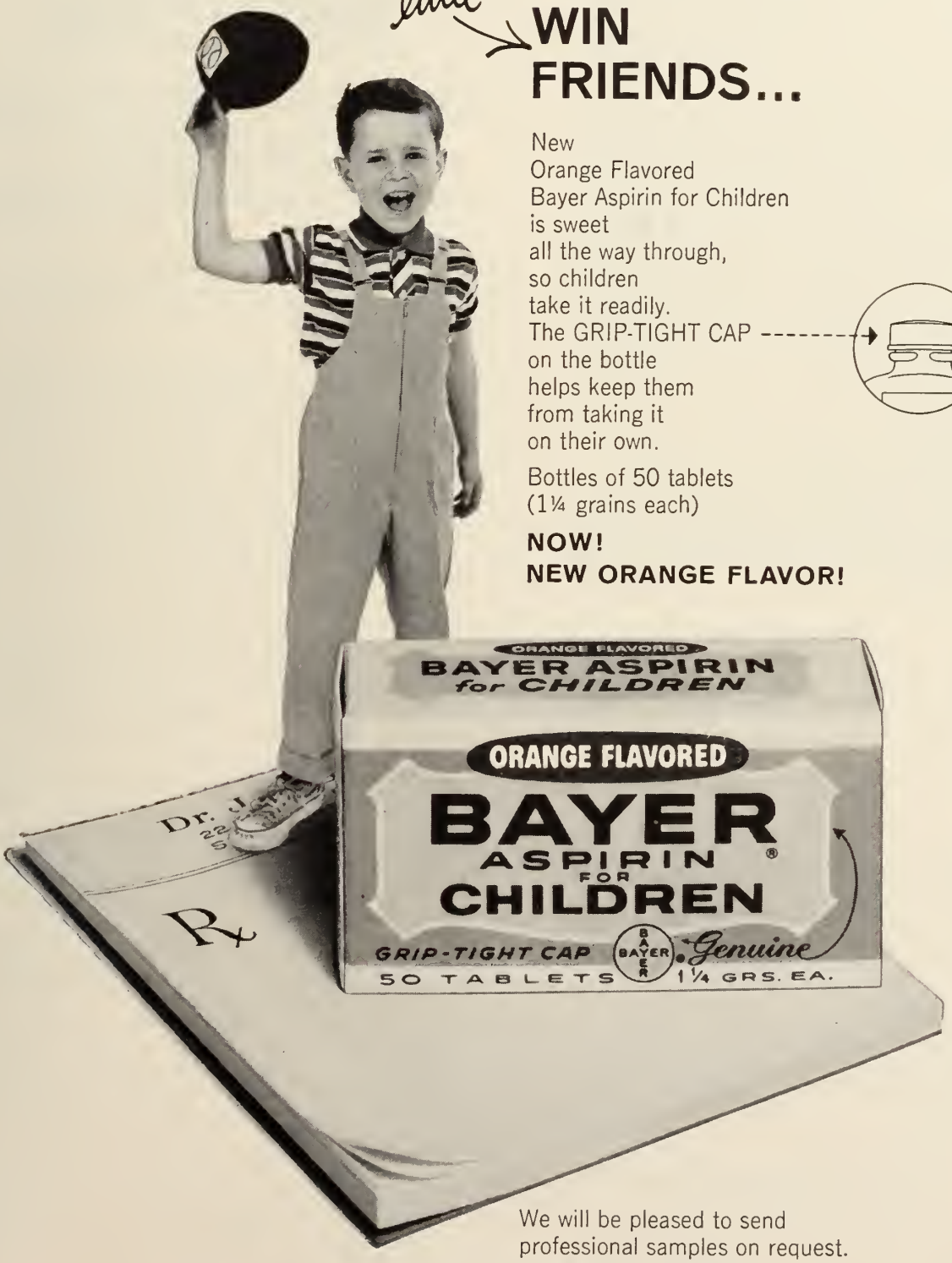
Complete literature available on request from Professional Services Dept. PML.

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NEWS BRIEFS

The new mayor of Cheboygan is **Carl Rauch, M.D.**, who also is beginning his second two-year term on the city council.

The Greenville Daily News recently printed a warm feature story about **Charles Stevens, M.D.**, who serves as mayor of Greenville. He started his practice in Stanton and has been in Greenville since 1956.

Three Marquette doctors are part of a study group considering the community-school approach, which is so successful at Flint. Meeting with the group are **James Carter, M.D., Norman Matthews, M.D.**, and **K. Charles Wright, M.D.**

The important role of the family physician in marriage counseling was discussed by **William Kirtland, Jr., M.D.**, Roseville, at the recent Detroit workshop of the Michigan Interprofessional Association on Marriage, Divorce and Family.

Winthrop N. Davey, M.D., professor of internal medicine at the University of Michigan Medical School, is the new president-elect of the American Thoracic Society, elected at the annual meeting in New York. The new president of the society is **William S. Schwartz, M.D.**, Oteen, N. C., **Paul T. Chapman, M.D.**, Detroit, is the secretary-treasurer.

Arthur M. Clark, M.D., Dearborn, recently obtained his law degree through extension courses at the University of LaSalle.

James Sanderson, M.D., Cadillac, discussed "Chronic Cough—Shortness of Breath" on a program over WWTV and WWUP-TV during a Michigan Health Council program.

One of five women recently cited at the White House by Mrs. Lyndon B. Johnson for "outstanding achievement" was **Ethel Calhoun, M.D.**, of Birmingham. She is the director of the Sister Elizabeth Kenny Foundation rehabilitation center at Pontiac General Hospital.

The new director of the Bay County Health Department and Medical Facility is **Neal R. Moore,**

Say you saw it in Michigan Medicine

M.D., who has practiced in Bay City since 1931. His father, G. W. Moore, M.D., was Bay City health officer from 1920 to 1946.

Richard J. Bing, M.D., Detroit, was a member of the American team of specialists who went to Europe in May to demonstrate new methods of treating heart disease in several countries there.

More than 225 colleagues, friends and relatives recently honored **John R. Ware, M.D.**, Port Huron, at a community testimonial dinner. He began his practice there in 1930.

A speaker at the Plymouth YMCA sex education program was **David B. McCubbrey, M.D.**, of Plymouth.

Donald M. Harris, director of the Branch-Hillsdale District Health Department for 12 years, will start his residency at Northville State Hospital on July 1.

The First Friday Club of Saginaw Valley recently heard a discussion on "Medical Ethics and the Roman Catholic Church" by **James T. Keyes, M.D.**, Bay City.

Serving as a member of a new Drug Research Board under the Division of Medical Sciences of the National Academy of Sciences, National Research Council is **Jerome Conn, M.D.**, Ann Arbor.

Steps to be taken to reduce the disability and death rate of heart, cancer and stroke victims are being considered by the new "National Health Commission," which includes **John Stirling Meyer, M.D.**, Birmingham. Doctor Meyer was appointed by President Lyndon B. Johnson.

Chairman-Elect of the Ingham County Chapter of the National Foundation is **George H. Agate, M.D.**, Lansing.

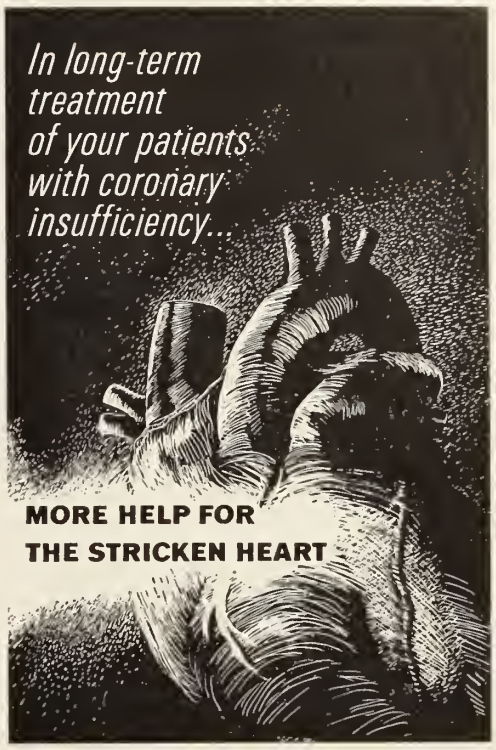
William G. O'Driscoll, M.D., Grand Rapids, will be the official American Medical Association representative to the Annual Meeting of the British Medical Association in Manchester, England, July 20-24.

For more than 20 years on the Association's board, **G. Rex Bullen, M.D.**, was honored by the Jackson County Tuberculosis Association at its annual meeting. He has maintained effective liaison between the Association and the Jackson County Medical Society.

One of the 17 physicians honored recently by the Ohio State University College of Medicine for 50 years of practice was **C. D. Barrett, M.D.**, Monroe. He has been in public health work in Ohio and Michigan for 48 years.

The new director of medical education for Hurley Hospital, Flint, is **Ramon R. Joseph, M.D.**, who formerly was an instructor at the U-M School of Medicine. He succeeds R. Roderic Abbott, M.D., now in private practice.

Speakers at the annual meeting of the Adult Education Association of Michigan included **R. E. Rowe,**



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M.D., Port Huron, who discussed problems of the aging and resources for meeting them.

A talk about "Granny's Herbs and the Witch-Doctor" was given by **C. Howard Ross, M.D.**, Ann Arbor, at the Olivet Bulb and Blossom Club.

Vice president for the recent respiratory disease symptom alert in Wayne County was **Max L. Lichter, M.D.**, Melvindale. The education effort continued from May 1 to June 15.

Wolf W. Zuelzer, M.D., Pleasant Ridge, spoke to the Wayne County Pathology Society on "Perspectives in Leukemia Research" in May.

Herbert L. Hazledine, M.D., Port Huron served as a member of the Committee to Study Dropouts in the Port Huron Area Schools.

An unrestricted grant of $5,000 for medical research has been presented by Wyeth Laboratories to **J. Robert Willson, M.D.**, Ann Arbor.

Edward R. Annis, M.D., president of AMA and a native of Detroit, was cited recently by Marquette University as the "Alumnus of the Year."

Two MSMS members addressed the Michigan Industrial Nurses Conference at Michigan State University—**Bert Brooks, M.D.**, Kalamazoo, about "Safe Use of New Drugs in Industry" and **Alexander Hirschfeld, M.D.**, Detroit, about "The Industrial Nurse Looks at the Accident that Hasn't Happened."

WSU Grads Choose 12 Cities In Michigan for Internships

Members of the 1964 graduating class of Wayne State University School of Medicine have decided to intern at Detroit, Ann Arbor, Pontiac, Grand Rapids, Grosse Pointe, Flint, Muskegon, Eloise, Kalamazoo, Dearborn, Royal Oak and Highland Park. Sixty-seven of the graduates have decided to remain in Michigan for their internship training. (Eighty-three of the University of Michigan graduating seniors also will remain in Michigan—see May issue for the news article.)

The report from WSU reveals also that 41 men and three women will intern outside of Michigan, with 18 men going to California.

Thirty-five will remain in Detroit for internships, with 10 going to Pontiac, three each to Grand Rapids, Grosse Pointe, Kalamazoo and Dearborn, two each to Flint, Muskegon, Eloise and Royal Oak, and one each to Ann Arbor and Highland Park.

Son of C. J. Lundy, M.D., Dies

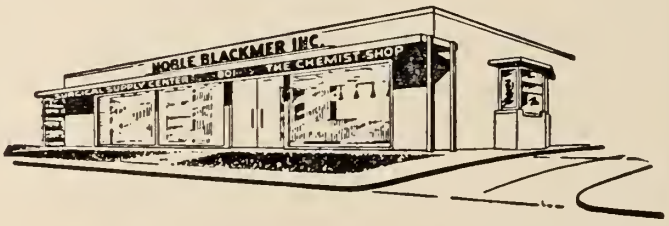
C. Bradford Lundy, M.D., who died in Detroit, May 12, 1964, was the son of C. J. Lundy, M.D., who was chosen as MSMS President-Elect in 1893 but died before taking office.

Doctor Lundy was a graduate of Michigan State Medical Society and the Detroit College of Medicine. A Navy veteran of World War I, Doctor Lundy retired in 1956. He long had been active in Boy Scout work.

Doctor Lundy was a brother of Mrs. Grace Lundy Drolett of Lansing.

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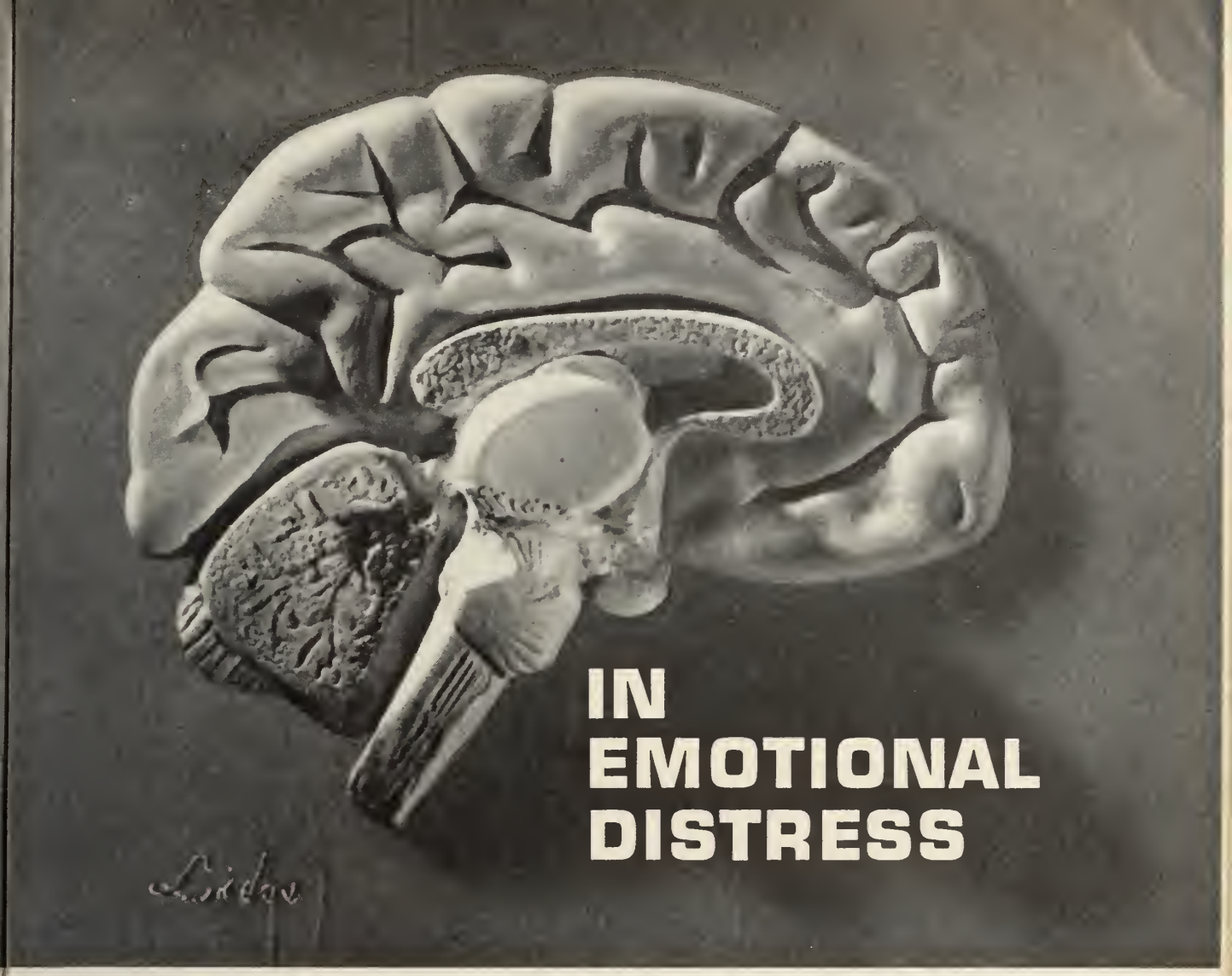
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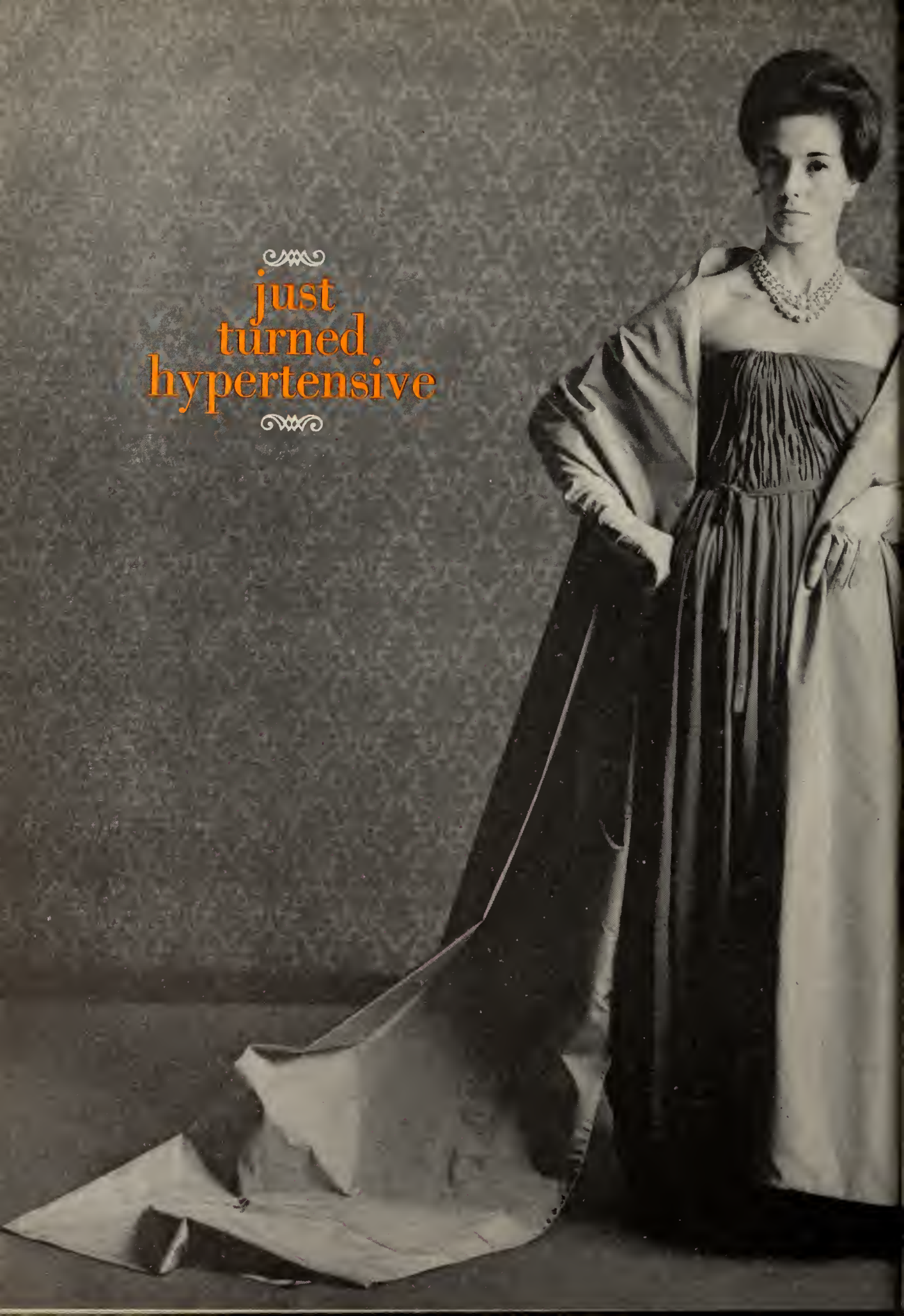
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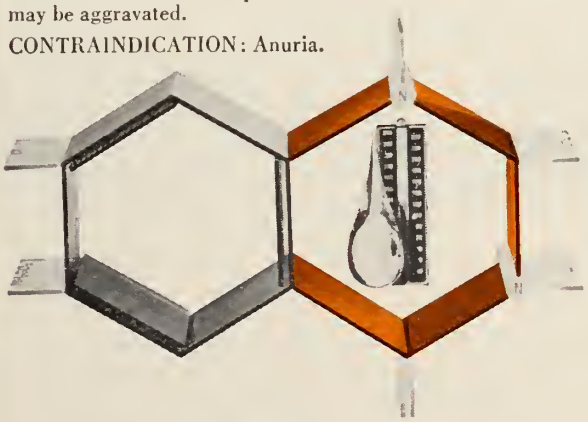
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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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SCIENTIFIC PAPERS

THE UNIVERSITY AND THE MEDICAL CENTER

BY ERNEST GARDNER, M.D., DETROIT

I welcome this opportunity to discuss Wayne State University and the Medical Center and to indicate some of the reasons for their development. One might well ask what a medical center is and why one is necessary for a modern medical school.

A medical center is a complex of resources for teaching, research, patient care, and community service. Here in Detroit, the center which is being developed involves Wayne State University, private hospitals such as Grace, Harper, Woman's, Children's and the Rehabilitation Institute, community and governmental agencies, and private industry, with the expert and invaluable aid of Crane and Gorwic in the general planning and supervision.

I must emphasize that the University, not just the medical school, is involved, and that the center includes much more than the University. Nevertheless, the key to a successful center is the University. Before its role can be defined, however, the important categories of all aspects of health care should be outlined. The functions of the University in health programs can then be clarified.

Doctor Gardner is Dean, Wayne State University Medical School.

These categories of health care are:

1. *Living Standards.*—The striking improvement in health during the past century owes much to improvement in standards of living, for example, in housing, education, and nutrition. These in turn are due as much to the efforts of the citizenry in general and to the advances in agriculture as they are to medicine.

2. *Prevention of Disease.*—The dramatic elimination of plagues in this country and the remarkable prevention of infectious diseases need no documenting. These advances have resulted chiefly from the efforts of health agencies. The private physician also has an important role insofar as he handles the immunization, diet, and hygiene of his patients. Indeed, pediatricians have succeeded so well in this aspect that they are perhaps the busiest and the most poorly paid of practitioners.

3. *Diagnosis and Treatment.*—This is the responsibility of the physician whether in private practice or full time on a hospital staff. The advances in diagnosis and treatment have come

"Training is instruction in techniques, but education involves teaching the student how to deal with problems not yet identified by methods not yet discovered."

chiefly from the education and research carried out by universities.

4. *Rehabilitation.*—This necessary sequel to most illness and disability is the primary responsibility of private and government agencies, especially in the case of patients with little or no income. Both the need and the cost are enormous, especially in neurological and psychiatric disorders. The private physician has a key role in initiating rehabilitation and in giving support, wherever possible, to the agencies and institutions concerned.

5. *Plans and Planning.*—The cost and complexity of modern medicine, the serious shortages of physicians, nurses, therapists, and technicians, require that the utmost attention and careful study be given to the various plans for meeting health needs. In recent decades, striking progress has been made in developing insurance plans and methods of practice designed to provide and pay for a high level of medical care.

6. *Education and Research.*—Although this category includes the education of the public, it refers chiefly to the functions of universities, including not only the medical schools, but also the paramedical or ancillary professions, for example, psychology, social work, occupational therapy, physical therapy, and medical technology.

* * *

A UNIVERSITY BY tradition is concerned with past, present and future, but the categories listed above, such as living standards and prevention of disease, are concerned chiefly with the current practice of medicine. In keeping with university tradition, a medical school must prepare students for tomorrow's medicine as well as for today's. No one knows what advances will have been made ten years from now, what new diagnostic methods will be available, what new drugs will be used, what new surgical techniques will have been developed.

Students today are sent forth into a world in which complexity succeeds complexity with such speed that few of the prescriptions written today could have been prescribed 10 years ago. Training is instruction in technique, but education involves teaching the student how to deal with problems not yet identified by methods not yet discovered.

It has been evident for many years that more physicians and many more of the ancillary personnel must be educated in order to serve the health needs of the increasing population. Among the recommendations of the 1963 Report of the Committee of the Michigan Coordinating Council for Public Higher Education, which considered medical education, was the following: that the entering class of medical students at Wayne be increased from 125 to 200. This increase will add the equivalent of another medical school in Michigan.

The Medical Center makes this increase possible, provided, of course, that the necessary funds are made available. It will also make it possible to develop new programs, to expand postgraduate education, and to carry out concurrent programs in the ancillary professions. Let me outline briefly some of the activities.

* * *

THE TEACHING to be carried out in the medical center includes undergraduate medical students, interns and residents, postdoctoral fellows, and practicing physicians. Indeed, the number of students will be so great that hospitals and institutions outside of the medical center will also be used. Teaching in the center also includes those students working for the Master's degree or the Doctor of Philosophy degree, and who are a significant source of faculty. Finally, the medical school will have direct responsibility for many aspects of teaching and training in the ancillary professions and certain technical areas. It must be emphasized over and over that modern, comprehensive health care involves much more than the physician and that educational institutions concerned with health teach many more kinds of students than medical students.

Research in the center ranges from basic biological studies on the one hand to applied clinical and technological studies on the other, and includes sociological and economic research.

Patient care requires carefully planned and designed inpatient and outpatient facilities, both private and public, with additional specialized facilities for certain kinds of clinical care and research. The community services should include emergency units, centers for acute alcoholism

and narcotic addiction, acute psychiatry, special units for infectious diseases, and special geriatric units.

* * *

IT IS CLEAR that the complex and expensive nature of modern medical education and research requires coordination in the form of a center in which the University and not just the medical school takes part. A solid relationship between biology and medicine must be developed, and the participation of nursing, occupational therapy, physical therapy, social work, sociology, anthropology, psychology, and education are vitally necessary. The medical school must take the lead in seeing to the proper interaction of all of these important facets.

The passage of the Aid to Medical Education Bill by the Congress in 1963 made it possible to begin planning for many parts of the center in terms of specific buildings and deadlines. This bill provides Federal money to match local funds for construction of new schools and expansion of existing schools. The bill was designed to stimulate expansion of medical education. It has succeeded beyond all expectations, in that more funds have been requested than are currently available.

* * *

LEAVING FOR THE moment the plans of private and public hospitals in the center, the University has built in the center the Medical Research Building, which will be finished and occupied in 1964, and it plans the following additional buildings:

1. A Basic Medical Science Building, for teaching and research, at a cost of about 16½ million.

It is a reasonable expectation that this part of the program will progress so that the first increase in class size will be about 1968.

2. A library, at a cost of about 2 million.

3. An outpatient building, at a cost of about 10 million.

4. A central vivarium, at a cost of about 4 million.

5. An auditorium, at a cost of about 1½ million.

6. Other buildings are also planned, including research buildings and institutes, central records and storage, data processing, and parking.

These buildings will not supply everything needed for teaching. Of critical importance are the inpatient units for clinical teaching. Just as physicians in private practice are a most important part of our teaching faculty, so the private hospitals in the medical center are a most important part of clinical teaching facilities. These hospitals, together with other hospitals and with new ones to be built, will be used in the teaching, training, research and service programs.

* * *

THERE IS NO DOUBT that the task of bringing together the University, the hospitals, the community, and private industry to form this medical center is a most complex and difficult one. The fact that it is difficult and complex makes the job an exciting and challenging one. I have no doubt that this can be and will be one of the finest medical centers in the world.

Assuming that the development of the medical center proceeds as planned, it might be of some interest to predict what will be the trends and problems occupying our attention 10 years from now, leaving aside the everyday problems of finding more money, staff, and space.

1. *The Changing Nature of Medicine and Research.*—These are too unpredictable to chance prophesying. However, I would like to make one comment. Biology, and medicine is a form of human biology, will be undergoing an expansion similar to that enjoyed by physics and chemistry during the past few decades. I hope that this expansion will include much more attention to what might be called environmental biology, that is, the relationship of an individual to his environment, including other individuals. This is in contrast to the biology which studies the inward aspects of an individual and aims at deciphering the secrets of the living cell.

2. *The Type of Professional Student.*—In recent years, biologists, chemists, physicists, and mathematicians of university faculties have written textbooks and designed curricula for elementary and high schools. Modern concepts are introduced in an exciting and challenging way. I am sure that students who have the opportunity to use these new things will enter college much better prepared and intellectually more mature. Some will go on to medical school, and the faculty must be prepared to adapt its teaching so as to be able to cope with these students.

3. *More Intensive Research in Education.*—Few faculties are more concerned with methods

" . . . the first increase in class size will be about 1968."

of teaching and few devote more time to it than do teachers of medicine. Nearly all are concerned that students graduating from medical school be prepared to strike off in any direction, including the unknown. We have not yet reached the utopia, and all of us will be heavily involved in studying ways of improving medical education.

4. *The Continuous Nature of Medical Education.*—Medical education will be even more of a continuous program, from the beginning of medical school throughout the life of a practicing physician. It is impossible, in four years of medical school, to teach all that a physician should know. The education and training during internship and residency will be a direct continuation of medical school, whether in association with a medical school or in a non-affiliated hospital. Continuing medical education will have expanded greatly, and the medical school will be involved with the educational programs of hospitals throughout the state.

5. *Foreign Medical Students.*—Every medical school, like every university, will be greatly concerned with the education and training of foreign medical students and graduates, here and abroad. The extent of this involvement is indicated by the fact that the Association of American Medical Colleges has seriously considered recommending that a medical school for foreign students be established in the United States. We shall be faced with the necessity of reconsidering our present methods. Too often we train someone in a modern medical center and expect him to return to an underdeveloped country with few of the facilities he had here. We must consider not only economics, but also religion, philosophy, and culture. These aspects, which are often unknown or are not understood or are misunderstood, have a profound influence on the learning and practice of medicine. Finally, we shall be much more heavily and directly involved in the setting up of teaching, training, and practice in foreign countries.

* * *

IN THIS BRIEF DISCUSSION, I have tried to make clear the complex nature of modern medical education and that a first-rate program requires a University, not just a medical school, working in cooperation with the private physician and with public and private hospitals and agencies. The medical center that is being developed provides a magnificent opportunity to serve the needs of the community, the state and the country. I have no illusions that the problems of development will have easy solutions, but at the same time I am confident that with the talents in the University and the community, we shall be successful.

Profile of "Typical" Young Physician

A recent survey conducted by the Student American Medical Association, under a grant from Merck, Sharp & Dohme, Inc., provides this interesting profile of the "typical' young physician:

1. He chose medicine as a career because of the humanitarian aspects of the work.

2. He was influenced by others in making his choice—primarily his family, with other physicians, including his family doctor, a close second.

3. Few people have counseled him against a medical career.

4. It's a 50-50 chance he considered dropping medicine during pre-med training.

5. He believes the burden for recruiting new people to medicine rests primarily with the individual physician.

6. He feels that the major deterrents to the study of medicine are the time, effort and amount of study necessary, with financial burdens of secondary consideration.

7. He would encourage others to choose medicine as a career, and would make the same choice again himself.

—Illinois State Medical Society Journal

Child Psychiatry

The development of child psychiatry as a medical specialty calls attention to the unique emotional life of children. Although an objective understanding has come slowly we now have a body of knowledge about normal and abnormal mental functioning in children. The relationship of children's emotional disturbances to family life, to maternal deprivation, to minimal brain injury, to school life, to mental retardation and social conditions has been demonstrated. In his work the child psychiatrist collaborates with other professional disciplines and is drawn close to community life. The child psychiatrist's interest in the direct treatment of the child and in constructively influencing the youngster's environment leads to emphasis on the family as the focus of treatment.

AN INTRODUCTION

BY JACK C. WESTMAN, M.D., ANN ARBOR

When the first certificates in child psychiatry were issued by the American Board of Psychiatry and Neurology in 1959, one more milestone was marked in society's long and arduous progress toward recognizing childhood as a unique period of life. Today there are some 300 board certified child psychiatrists in the nation. Although the number of fully qualified child psychiatrists is small, it may be well to sketch the origins, capabilities, limitations and prospects of this specialty.

The basic idea that a child is something other than a miniature adult appeared quite recently in the history of medical thought.[4,7,8] In this matter the physician lagged somewhat behind the lawyer, the philosopher and the teacher.

The magistrates of twelfth century England sensed children's uniqueness when they held that a child was incapable of criminal intent if under the age of seven. In the eighteenth century, Rousseau declared that the child's nature was basically good and worthy of expression. And Froebel recognized the special needs of the child by developing the kindergarten movement in Germany during the first half of the nineteenth century.

But adults traditionally have found it difficult to be objective about the rising generation which poses many irritations and threats. We have emerged from a period of inhumane and oppressive domination of children by adults. Remnants of this attitude persist to the present time, but in the over-all picture, the pendulum has swung to the opposite extreme. Some of the past restrictiveness was based on fear of children's unbridled tyranny, signs of which appear in some quarters of present-day society. The historical swing between extreme attitudes toward children is repeated today in that many adults advocate either more strictness or more permissiveness in the matter of discipline. Suffice it to say that adults often have strong feelings which have hampered the study of children.

* * *

THE EARLY ROOTS of child psychiatry may be traced to 1800 when Itard, through his work with the Wild Boy of Aveyron, demonstrated that mentally defective children could be trained. Textbooks during that period referred to insanity of childhood as a rare condition resulting from degeneration of the brain, heredity or excessive masturbation.

Subsequent developments came slowly. A century later psychiatrists had gained enough understanding to urge establishing the juvenile court system and to recognize child offenders as individuals with special circumstances leading to their criminal behavior, rather than as insidious young adults deserving the vengeance of an outraged society.

The momentum increased at the turn of the 20th century. Binet developed tests for evaluating intelligence. Freud traced the roots of

From the Department of Psychiatry, The University of Michigan, Ann Arbor, Michigan.

adult neurosis back to childhood, and Jacobi furthered the recognition of pediatrics as an area of specialization.

By the 1920s, child guidance clinics brought together psychiatry, social work and psychology as communities began to grapple with the problems of troubled children. Textbooks on child psychiatry appeared: Tramer's German Text introduced the term child psychiatry in the early 1930s and Kanner's *Child Psychiatry* appeared in this country in 1935.

The first chair of child psychiatry was established under the influence of Adolph Meyer at Johns Hopkins University in 1930 for Kanner, and formal recognition of the specialty was accorded by the American Board of Psychiatry and Neurology in 1959.[1] The Board's criteria for eligibility include two years of training in adult psychiatry beyond internship, followed by two years of training and two years of practice in child psychiatry.

CHILDHOOD: THE CRITICAL PERIOD FOR PERSONALITY DEVELOPMENT

Luckily for mankind, children have an overwhelming tendency toward sound emotional health. Nevertheless, experiences of early life may have unfavorable later repercussions. For the most part, potent events and consistent misunderstanding on the part of parents are required to produce an emotionally disturbed child. Most traumatic experiences in childhood show their influence in adulthood when overt neurotic symptoms appear. Their effects during childhood are less obvious. Gross emotional disturbance in a child is usually more serious than a similar problem appearing in adult life. The earlier the breakdown, the more malignant is the illness.

There is a popular view that the dividing line between the psychotic and the genius is very thin indeed. Psychiatry often finds itself in agreement. Descriptions of Albert Einstein as a child coincide with accepted criteria for the diagnosis of psychosis. Many normal children have marked adjustment problems. Yet follow-up studies[3,9] show that untreated disturbances of childhood can lead to adult mental disorder. As yet undefined "circumstances" determine whether the child who stands apart from his fellows later becomes a mental patient or a talented genius.

The attainment of emotional health, without squelching potential talent, occurs in a home governed by reasonably mature parents who recognize the child's unique needs for self-expression and, at the same time, provide him with intelligent rules and guidance. The homes of children who find their way to psychiatric clinics are not run by reasonable adults. Some parents make exorbitant demands upon their children, some involve their children in a complicated web of their own neuroses and others abdicate their authority to their children.

At the risk of over-simplification, we might note some guideposts along the road to mental health:

Age 0-1.—Complete gratification of the child's needs helps establish a good feeling toward the world as a foundation for later life.

Age 2-3.—The child begins to learn how to tolerate frustration and accept limitation of his own wishes. Negativism and temper tantrums are an expected part of this process.

Age 3-6.—He comes to grips with feelings about parents and siblings. Unreasonable fears and extremes of love and hostility toward parents are expressed.

Age 7-12.—He develops skills and finds a place in the larger world, often swinging a little too far toward over-conscientiousness or naughtiness.

Adolescence.—Stormy fluctuations in mood appear as he reluctantly leaves childhood and enters the adult world. Alteration between the extremes of idealism and disgust with the world are part of this transition.

CONCEPTS OF CHILD PSYCHIATRY

Despite its comparatively short professional history, child psychiatry has accumulated a body of facts, guides and concepts which help detect and treat problems arising in the growth of individual personality.[2,5]

One basic concept is that the child's attitude toward himself inevitably reflects the feelings his parents express toward him as a spiritual and physical being. The psychiatrist seeks clues to these attitudes through study of feeding practices, cleanliness routines, toilet training and the like. The parents' feelings toward the child's body and its functions shape his basic attitudes toward himself. There is a universal tendency for the child to model himself after his parents' *behavior*, rather than their *teachings*, so the diagnostician must probe far beneath superficial appearances to glimpse the crucial parts of family life.

This interplay between parents and children may produce the *emissary phenomenon* in which the child who is presented for treatment turns out to be merely a "symptom" of a more serious problem elsewhere in the family.

Another significant clinical phenomenon is *maternal deprivation*: retarded, emotional, social and physical development is often found in children deprived of a mothering figure—particularly during the latter two-thirds of the first year of life. This concept and its ramifications has served

to encourage early adoption and placement of infants in intact homes.

Psychiatrists were long baffled by a group of children who had difficulty in perceiving the world. Their secondary behavioral and emotional reactions indicated—but for no clear cut reason—some basic problem in learning. It has since been recognized that *minimal brain injury* is present in these children without a known history of brain damage or cerebral infection. This finding has stimulated more intensive study of pregnancy and birth, especially the traumatic nature of labor, anesthesia and other factors producing relative anoxia.

The syndrome of *school phobia* has been identified with its characteristic history, clinical findings and course. Typically, the patient refuses to attend school because of a variety of factitious somatic complaints and fears. The core of the syndrome is the mother and child's reluctance to separate from each other. Most cases respond favorably to coordinated effort of the physician, school and family to return the child to the classroom as soon as possible with subsequent exploration of the underlying causes.

Pseudo-feeblemindedness has been closely studied by child psychiatrists leading to a deeper understanding of the contribution of social and psychological factors to the problem of mental retardation. Significant increases in I.Q. are commonplace when psychiatric resources are brought to bear on the mentally retarded population.

Neurotic *learning inhibitions* play an important role in the large group of children who underachieve in school. The fact that some children "need" to fail, a common finding among patients reaching the child psychiatrist, has shed light on many puzzling school problems.

Current approaches to juvenile delinquency bear the imprint of the psychiatrist's emphasis on the *individual delinquent* as opposed to lumping all delinquents together as a uniform social problem. Many youngsters from respectable homes break the law as a means of expressing deep-seated emotional conflicts or hidden family disorder.

THE FUTURE OF CHILD PSYCHIATRY

The practice of child psychiatry reflects the shift of the psychiatrist from the isolated hospital or consulting room to the community. Improvement in most emotionally disturbed children is dependent on constructive change in the home and school in addition to direct therapy with the child. The child psychiatrist's effectiveness is, therefore, increased through collaboration with social workers and psychologists. There is a growing tendency to employ the child psychiatrist in consultation with a concert of community agencies and other specialists: physicians, social workers, psychologists, lawyers, vocational guidance counselors, courts, welfare agencies, public schools, and nursery schools.[6] This trend may ameliorate the shortage of trained child psychiatrists by improving the skills of other professionals working with children.

While psychiatric hospitals for children have sprung up about the country, most residential treatment will probably continue to be conducted in non-medical institutions supported by religious, charitable and private groups. The first inpatient psychiatric unit for children was established at Bellevue Hospital in New York City in 1921. The first children's psychiatric hospital in a university medical setting was opened at the University of Michigan in 1955.

A significant recent development is day treatment for children. This offers the quality of care customarily found in hospitals, and the added benefit of keeping the youngster in touch with his community and family environment, at considerably less cost. Such day treatment centers can be established in hospitals, child guidance clinics, mental hygiene centers and in the public schools.

The future also promises a shift in social attitudes toward children. Hopefully, there will be a more realistic understanding of the differences between the worlds of the child and the adult. In addition there will be a greater appreciation of the rights of children. In this connection, we may expect a more candid appraisal of home fitness. Many of today's homes specialize in turning out emotionally disturbed children and delinquents. Since there may be no demonstrable *physical* neglect, the youngsters cannot be removed from these homes under existing legal practices. However, as the future brings us a more clear cut definition of *emotional* neglect, we should expect to develop more effective forms of relief for parents and children from homes that are pathogenic for both. In many states the fates of children are determined piecemeal in both circuit and juvenile courts. The practice of family law in consolidated family courts would reduce the fragmentation of the family in important legal actions.

For a youthful specialty it seems inappropriate to raise the question of changing its name. Yet the emphasis placed upon the family in the diagnosis, treatment and prevention of emotional disorders in children leads the child psychiatrist to practice more as a *family* psychiatrist. His raison d'etre, however, is for troubled children, and it is likely that the label *child* psychiatrist will remain.

(References on Page 495)

BY WILLIAM W. COON, M.D., ANN ARBOR

Some Considerations In the Systemic Use Of Fibrinolytic Agents

The normal homeostatic mechanism for the disposal of intravascular thrombi involves the activation of a precursor of a fibrinolytic enzyme circulating in human plasma. This process is an important contributor to the re-establishment of blood flow in vessels injured by accidental trauma, operative procedures or disease.

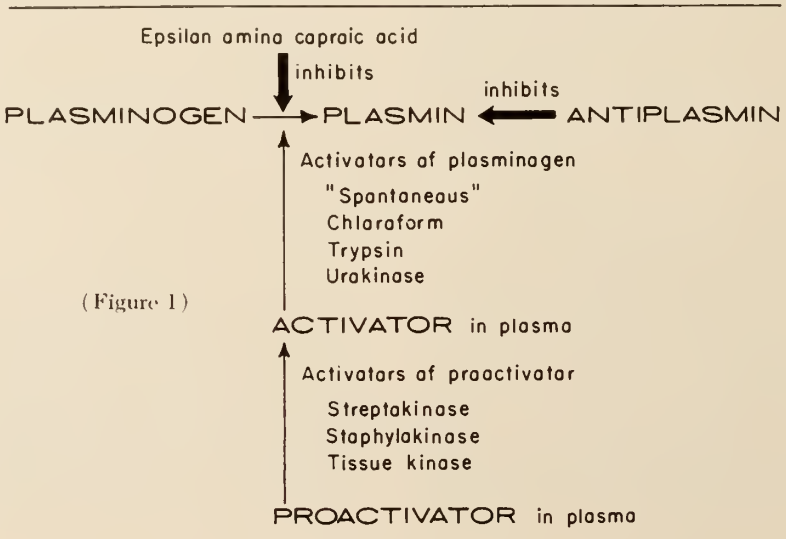
In the past few years, considerable interest has developed in the potential use of one or more components of this enzyme system as therapeutic agents for the treatment of thromboembolic disease. A valid statistical assessment of the utility of this approach has not yet been made.

Our knowledge of variables influencing lysis of intravascular thrombi is still limited. Until more information is obtained concerning the clinical pharmacology of fibrinolytic agents, no true appraisal of their therapeutic value can be made. As prior studies of other agents have shown, ten or more years pass before the initially over-enthusiastic estimates of a drug's usefulness are tempered by accurate and adequate clinical experience.

A scheme outlining the more important components of the fibrinolytic enzyme system and agents affecting its activity is presented in Figure 1. Plasminogen and antiplasmin are normally present in circulating plasma; proactivator is pre-

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(Figure 1)

sumably present also but this has not yet been proven.

The nature, source and physiological mechanism of activation of plasminogen activator are still undetermined. The physiological activation of this enzyme system probably involves the release of tissue kinase which facilitates the conversion of proactivator to activator; in turn, activator is responsible for the conversion of plasminogen to the active fibrinolytic enzyme, plasmin. Antiplasmin which is present in excess in plasma rapidly binds to and inactivates plasmin. This latter mechanism serves as a homeostatic defense against uncontrolled proteolysis. If plasmin continues to circulate in high concentration in uninhibited form, proteolytic degradation of fibrinogen and probably other plasma proteins as well may occur.

Several different approaches to the use of this enzyme system for fibrinolytic therapy are available. One may administer an agent, e.g., streptokinase or urokinase, which acts through activation of the individual's own circulating plasminogen. On the other hand, one may infuse an exogenous source of human plasmin. Frequently, both techniques are combined when combinations of streptokinase or urokinase plus exogenous human plasminogen are administered together. The optimal method of treatment or the relative merit of one technique over another has not yet been determined.

* * *

SOME OF THE controversial problems which have been debated heatedly in the past several years are summarized below:

1. Is the administration of "activator" alone a desirable form of therapy? Both pyrogenic and antigenic reactions have been associated with intravenous infusions of streptokinase. The incidence of pyrogenicity has been reduced as purity of this agent has been improved. Antigenicity is more serious, however; since severe anaphylactoid reactions have been reported, a second course of therapy is unwise.

In addition, antistreptococcal antibodies may produce rapid binding and inactivation of streptokinase, limiting its effect in inducing endogenous activation of plasminogen. The "baseline" levels of antistreptokinase vary considerably from one individual to another; induction of a fibrinolytic effect, then, is dependent upon prior determination of antibody titer and administration of a dose in excess of that necessary to bind with antibody.

Another objection to "activator" alone is that total fibrinolytic activity induced is contingent upon the amount of plasminogen circulating in the patient's blood. Once plasminogen levels have dropped to zero, no further fibrinolytic effect can be expected. Some investigators have proposed that the amounts of circulating endogenous plasminogen are adequate for lysis of thrombi. Our studies of amounts of plasmin required to lyse human thrombi *in vitro* and the monitoring of infusions of plasmin in concentrations several times greater than the total estimated to be derivable from complete activation of endogenous plasminogen make us question this premise.

Another postulate is that the major effect of "activator" is mediated through absorption of the "activator" by the intravascular thrombus with subsequent activation of plasminogen within the thrombus itself. In our studies of *in vitro* lysis of human thrombi removed at operation, "activator" alone (streptokinase) was incapable of inducing dissolution of the thrombus, either because of inadequate absorption of "activator" or, equally, if not more likely, too low a concentration of plasminogen within the thrombus.

2. Will exogenous plasmin alone produce lysis of thrombi? On the basis of our studies with a preparation of spontaneously activated human plasmin* (presumably free of "activator"), the answer is a qualified "yes." Qualifications relate to our still extremely limited knowledge concerning the time-dosage requirements for an optimal lytic effect *in vivo* and the nature of the thrombotic disease which one is treating. The very fact that as more and more articles concerning the clinical use of fibrinolytic agents appear, higher and higher doses are recommended suggests to us that selection of cases and methods of evaluation have been based more on whimsical optimism than objective criteria.

3. Should anticoagulant therapy be used in conjunction with fibrinolytic therapy? On a theoretical basis, the use of anticoagulants following successful lysis of a thrombus would appear imperative. Thrombosis results in a change in vascular intima which may persist for a period of weeks after the thrombus is removed or lysed. For this reason, re-thrombosis would be highly likely if heparin therapy were not used for a considerable period immediately following the termination of plasmin administration.

Some investigators have recommended the use of heparin concomitant with the infusion of plasmin. Since the simultaneous influence of two agents, both having an effect on the clotting mechanism, greatly increases the hazard of bleeding, we have been reluctant to administer both at the same time.

4. Are any antagonists available if exces-

*Kindly supplied by the Michigan Department of Health for investigational use.

sive bleeding occurs during fibrinolytic therapy? Oral or intravenous administration of epsilon-aminocaproic acid will inhibit plasminogen activation. Therefore its primary usefulness will be in reversal of effects produced by administration of "activator." Although this agent may have some inhibitory effect on plasmin as well, insufficient information exists to place any reliance on this drug as an antagonist of plasmin itself. Although several protein fractions from plasma have antiplasmin activity, these isolated fractions have not yet been processed for clinical use. Platelets themselves also have definite antiplasmin effects.

Until specific antagonists to plasmin are available, management of fibrinolytic bleeding should include the administration of lyophilized fibrinogen and transfusion of whole blood.

5. Should these agents be employed as part of the routine armamentarium in the treatment of thrombotic disease? In our opinion, not yet. The potency of preparations available for routine clinical and for investigational use is highly variable from one preparation to another and yet, until very recently, each product has been assayed in a different unitage. The individual investigator has had to assay these preparations himself in order to compare potency.

Our studies which are still very preliminary suggest to us that enormous doses may be necessary for lysis of thrombi even under relatively optimal conditions. Even small doses of the commercially available preparations are quite expensive. Until more is known concerning dose, rate and route of administration, duration of therapy and selection of subjects for treatment, it is our feeling that these agents should be restricted for use in clinical investigation only.

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PROBABLY THE MOST difficult problem which we face in the evaluation of fibrinolytic therapy is the establishment of objective methods for assessing whether the thrombus has been lysed and whether this form of treatment has altered the course of the disease.

Deep venous thrombosis involving the leg or pelvic veins is a very prevalent and ubiquitous condition, but it is also very difficult to recognize. Our clinicopathologic data have shown that we recognize clinically only about 10 per cent of all deep venous thromboses. Those patients in whom the diagnosis is made present with the more easily identified inflammatory manifestations of thrombosis (pain, increased heat, tenderness, et cetera) which occur only after the thrombus has been present for 48 to 72 hours or longer. Even in those with asymptomatic edema of an extremity, extensive proliferation of a "bland" thrombus must take place before venous channels are sufficiently obstructed to produce manifest edema.

Unfortunately, a number of prior studies have shown that lysis of thrombi greater than 48 to 72 hours old by fibrinolytic agents is usually incomplete if not minimal. Early recognition, then, of deep venous thrombosis susceptible to lysis by plasmin is a very serious if not insurmountable problem. The same is true, in somewhat lesser degree, for superficial venous thrombosis.

Venographic evaluation of the results of therapy is also plagued with technical problems which have often not been appreciated. Failure of filling of a venous channel may be due not only to thrombosis but to vascular spasm, to poor timing of films or to a wrong positioning of the limb. Spontaneous lysis of venous thrombi may take place or, if venography is performed late in the course of the disease, recanalization may have occurred. In addition, unless a very dilute radiographic medium is used, its irritant effects may actually induce thrombosis.

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EQUALLY DIFFICULT is the objective assessment of this therapy in massive, potentially fatal pulmonary embolism. Over half of the patients who die from pulmonary embolism succumb within fifteen minutes of onset of symptoms and signs, and many of the remainder are dead within one hour. Rapid institution of therapy and successful lysis of an embolus within this period of time seems highly unlikely. How does one assess therapeutic benefits in non-fatal pulmonary embolism? Would the performance of pre-treatment and post-treatment angiograms be justifiable and would their evaluation be valid without a simultaneous control series to assess the incidence of spontaneous dissolution or recanalization?

A similar problem exists in the utilization of fibrinolytic therapy in the treatment of coronary thrombosis, cerebral thrombosis and complete central retinal artery occlusion. Within a short period of time (usually considered to be one hour or less), irreversible tissue damage has occurred. Successful lysis of a thrombus after this period may have some beneficial effects on revascularization of the infarcted area, but immediate benefit will not be remarkable. Assessment of long-term value would require an extremely large and very well-controlled study of patients followed over many years. In addition, arterial thrombosis (in these and in peripheral vessels) is often superimposed upon extensive pre-existing atherosclerotic narrowing which fibrinolytic therapy would not alter, and if lysis of the thrombus were induced, re-thrombosis would be highly likely.

(Summary is on Page 495)

Diagnosis of Aortic Dissection, With Particular Reference To Angiography

BY THOMAS A. BRUCE, M.D., DETROIT

During the past several years our understanding of the causes and the natural course of dissection in the major vessels has undergone considerable change. Even the fundamental terminology of the past is changing with the plea to no longer speak of *aneurysm*, since the involved artery may not be visibly enlarged, but of dissecting *hematoma*.[1]

Most important of all, the management of this condition is beginning to merge from watchful neglect to active reconstruction or replacement of the diseased area. These developments have not only clarified a good deal of the clinical mystic of aortic dissection, but have resulted in a demand for earlier and more specific anatomical delineation of the abnormal area.

PATHOGENESIS

The standard mechanism of aortic dissection to be found in most textbooks is that an atheromatous plaque ruptures into the aortic lumen, allowing blood to pass through the intima and extravasate between the coats of the aorta. That this was not always the mechanism became evident when patients were found with dissection of the media which did not communicate with the lumen.

Furthermore, the intimal tear associated with dissection frequently is not located at or near atheromatous changes. Conversely, ulceration of atheromatous plaques can be seen in many instances without associated medial dissection. The accumulation of large numbers of case reports of aortic dissection in young people without significant arteriosclerosis was an even greater stimulus to find a more basic mechanism for the dissection.[2]

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Pathologists have long noted an unusual amount of thinning of the aortic media in patients with dissection, and, after Erdheim, have termed the lesion "idiopathic medial necrosis." In contrast to the normal media, an elastic-collagen complex of remarkable strength, the media characteristic of idiopathic degeneration shows marked increase in thin-walled vasa vasorum, lying essentially unsupported in a loose connective tissue bed with an absolute loss of elastic fibers and smooth muscle cells. Microscopic hemorrhage can often be seen locally around these thin-walled vessels, suggesting their great vulnerability to rupture. Massive hemorrhage with subsequent medial dissection also occurs, and most of the intimal tears are from the wall into the lumen, rather than from the lumen into the wall.

Thereafter, escape of blood from the lumen into the false channel may extend the dissection, and re-entry into the lumen at the lower level may arrest the process. In the abdominal aorta primary intimal tears through an ulcerated atheromatous plaque may occasionally develop into a short area of dissection.

The major problem has been in finding the cause of the medial degenerative process. In far too many cases there has been no evidence for arteriosclerosis. Medial dissection in syphilitic aortitis, where there is also known to be degeneration of elastic forces and proliferation of the vasa vasorum, has been rare. This apparently is due to the severity of the inflammatory reaction, so that the vasa are thickened (not thinned) with an endarteritis, and are surrounded by dense fibrous tissue.

Hypertension is found in many patients with aortic dissection, but probably has no basic relationship to the medial necrosis. Rather, the

high vascular pressures result in more frequent and more severe hemorrhage in the already weakened vasa vasorum.

A helpful lead came from the study of aortic dissection in young people.[2] It was noticed that there was a high incidence of vascular congenital defects, such as coarctation of the aorta, bicuspid aortic valves, arachnodactyly with dislocation of the lens (Marfan syndrome), aortic hypoplasia, patent foramen ovale, ventricular septal defect, patent ductus arteriosus, and dilatation or aneurysm of the aortic sinuses. Because of the high incidence of associated congenital defects and the occurrence of dissection in familial patterns, it seems likely that the degenerative defect is in itself a congenital abnormality. Attempts to isolate a specific connective tissue abnormality have been unsuccessful, but insight has been gained into the nature of the problem.

Most of the investigations have been based on the observation that there is alteration of the ground substance in the media. Serum mucoproteins have been found to be normal or somewhat low, and acid mucopolysaccharides are high in the Marfan syndrome. An increased excretion of hydroxyproline has also been found, suggesting that the defect involves collagen in addition to elastic tissue. Attempts to estimate gene mutation rates in these disorders have been attempted but have been extremely difficult. It is doubtful whether a specific gross chromosomal aberration exists in the Marfan syndrome.

Whether all individuals with aortic dissection (except the few short abdominal dissections which may be due to arteriosclerosis) should be considered in the Marfan group is a problem. Relatives of individuals with the typical Marfan syndrome often have atypical or "forme fruste" skeletal and ocular features of the syndrome, but maintain a high incidence of aortic dissection. There seems little other advantage in such a classification at this time, however. Medial degeneration may well not be a specific lesion, but the final common pathway of a number of connective tissue disorders. It can be produced experimentally from ingestion of sweet pea meal (lathyrium), with the toxic component most likely β-aminoproprionitrile.

Dissection has also been recorded in pseudoxanthoma elasticum and the Ehlers-Danlos syndrome, connective tissue disorders unrelated to the Marfan group. To speak of all dissections as a variant of the Marfan syndrome, moreover, would invite confusion since the features of the syndrome are well defined[3] whereas the manifestations of the dissection group are protean. As an example, congenital heart deformities have an increased incidence in dissection, but are almost unknown in the Marfan group.

Dissection may, at times, occur in arteries other than the aorta and its immediate branches. Such events are uncommon, but primary dissection has been reported in the carotid, subclavian, renal, femoral, splenic, and pulmonary arteries with pseudoaneurysmal deformities of the mitral valve and the ventricular membranous septum.

CLINICAL FEATURES

The classical aspects of aortic dissection have been reviewed in a number of excellent papers during the past few years,[1,4] and need only be summarized here. The most characteristic finding is pain, usually sudden in appearance and most often in the substernal area. Onset is usually spontaneous, although a history of unusual physical or emotional exertion is not uncommon. The pain is usually severe and unrelenting, even with narcotics; often there is radiation into the neck or, more commonly, the back. Pain may occasionally be entirely absent. Prodromal symptoms may be noticed for weeks or months in a few patients. Peripheral pulses may or may not be feeble or asymmetrical, depending on the extent and location of the dissection.

Frequently, patients complain of pain in the extremities because of vascular occlusion. Severe, nonlocalized abdominal pain may predominate, with nausea, vomiting, and an urge to defecate.

The disease may at times appear to be primarily neurological (dizziness, headache, syncope, hemiplegia, paraplegia) or even psychiatric. Spinal cord damage results from occlusion of the intercostal or lumbar arteries, producing paraplegia. That this happens only occasionally is probably due to location of the dissection along the outer portion of the arch and down the left descending aorta, so that the arteries arising on the right side (including the renal) are spared.

Many patients develop congestive heart failure and cardiomegaly. Aortic insufficiency may be found on examination, indicating that the dissection has occurred within a short distance of the aortic valve ring. An aortic systolic ejection murmur is nearly always present due to the dilatation of the ascending aorta. Pericardial friction rubs may be heard when there is leakage of blood into the pericardial space from the medial hematoma. Systolic thrills are often present over partially occluded peripheral arteries.

Hemoptysis, hematemesis, or melena may be present when there is leakage of blood into the lung or intestinal tract. Rarely, dissection of the pulmonary artery is the cause for the hemoptysis. When one or both renal arteries are involved there is often gross hematuria. Renal infarction

occurs in only a fraction of the patients with renal dissection.

Hypertension is present in about half the patients, more commonly in the older group. Pregnancy has also been shown to have an increased incidence of aortic dissection. It usually occurs prior to the onset of labor, most often in the third trimester.

Because of the severe pain, with frequent dyspnea and shock, myocardial infarction is almost always suspected and may, in fact, be present if the dissection shears off one of the coronary ostia. Other common suspected diseases are spontaneous pneumothorax, pulmonary embolism, mesenteric artery thrombosis, acute pancreatitis, perforated peptic ulcer and ureteral colic.

COURSE OF THE DISEASE

The seriousness of the dissection depends on the extent and original site of the intramural hematoma. Dissections which begin in the ascending aorta commonly break through into the lumen 1 or 2 cm. above the aortic valve, or they may rupture externally with death usually resulting. The hematoma may extend only to the proximal aortic arch, or it may surround the entire aorta, crescent shaped, to the iliac bifurcation and beyond. Dissections beginning in the descending aorta may also be localized to a small portion.

In their review of 425 cases, mostly of the older group, Hirsh and associates[4] found that 3 per cent of deaths occurred immediately, another 18 per cent within the first 24 hours, and still another 16 per cent by the end of the second day. On the fifth day less than half of the patients were living. At one month, 20 per cent were still alive, and at one year only 7 per cent were alive. These figures include dissection at all sites with no surgical intervention.

By far the main cause (89 per cent) of death within the first two weeks was erosion of the dissecting hematoma outside the aorta. The pericardium, pleura, mediastinum, and abdomen were involved, in that order. More than half of the causes of late death were for the same reason, and cardiac failure accounted for about one-third of late deaths. Those patients with aortic dissection arising below the left subclavian artery, however, had a three times better chance of surviving for six weeks than those with dissection in the ascending and arch portions.

The objective of surgical intervention in aortic dissection is to prevent the external rupture which is so often fatal. Often the creation of a second communication (fenestration) between the true and false channels at the distal end of the dissection will result in a significantly better chance of survival. Sometimes the weakened area is reinforced, as with cellophane wrapping. DeBakey and his associates have pioneered in graft replacement of the diseased areas.[5] They use fenestration only for the dissection which extends from the ascending aorta or arch to well below the diaphragm. Localized areas in ascending or descending portions are either resected or obliterated. They have reported 75 per cent overall survival in 72 patients operated for dissection, with 80 per cent successful results on descending thoracic lesions using aortic graft replacement under hypothermia or the bypass pump.

LABORATORY STUDIES

The blood hemoglobin and hematocrit are normal except where there is external leakage of the dissection, as into the pericardial or pleural cavities; a progressive anemia may then be seen over two or three days, accompanied by increasing bilirubinemia. The leukocyte count is usually elevated 10,000 to 20,000, and occasionally much higher. The sedimentation rate is elevated. Serum tests for syphilis are rarely positive. Gross hematuria is evidence for renal infarction but microscopic hematuria usually suggests only pre-existing renal disease. Azotemia occurs in half of all patients with dissection, but correlates poorly with renal occulsion, being pre-renal in type. Serum transaminase levels are normal or only slightly elevated unless there is infarction of an organ, hemorrhage into a serous cavity, or congestive heart failure resulting in acute hepatic engorgement. Serum amylase values may be elevated if the splenic or mesenteric arteries are occluded.

Electrocardiographic changes are frequently seen, but are nonspecific in nature. Right bundle branch block and ventricular hypertrophy may reflect underlying congential defects and not be related to the dissection *per se*. ST segment depression and T wave inversion, particularly in the posterior leads (II, III, AVF), are common. Left ventricular hypertrophy may be seen when aortic regurgitation has been present for some time. The injury pattern of pericarditis may be seen over one segment or in all leads when hemopericardium occurs. Changes in axis deviation due to the dissection are unusual. The feature of greatest help in differential diagnosis is the absence of a myocardial infarction pattern. Difficulty may occur, however, when dissection leads to infarction by occlusion of a coronary artery.

Radiography usually provides the means for diagnosis of aortic dissection when the history and physical examination are incomplete or

atypical. Widening of the aortic wall is usually not well seen on plain chest films, although nonspecific changes are often present. The most important sign is a sudden change in caliber on serial films. Holesh discusses at some length the radiographic findings.[6] In the acute phase the aortic arch may appear "unsharp" and somewhat uncoiled. If aortic insufficiency or hemopericardium occur the heart shadow is enlarged. If left hemothorax occurs the left border of the heart is obscured. If mediastinal leakage is present there may be widening and fuzziness of the whole superior mediastinum.

As recovery occurs, the knuckle of the aortic arch becomes more clearly defined, sometimes even normal. Usually, however, the arch is a little higher and wider than normal, and a double-contour shadow may possibly be seen. The dissection or false channel is filled with hematoma and is therefore relatively radiolucent. If the radiolucent shadow approaches 1 cm. width, dissection is likely. Luetic aortitis, pericarditis, and pleuritis can occasionally cause lesser degrees of radiolucency. Irregularity of the descending aortic contour and sudden change in caliber near the diaphragmatic hiatus are notable signs. When the innominate and subclavian arteries are occluded, rib notching may gradually appear as evidence of the anastomotic channels that have formed.

Calcified atherosclerotic plaques in the arch or descending aorta may be of considerable value in determing the presence of a second lumen or hematoma. Occasionally intimal calcification will mark the entire wall of the normal channel, and leave no doubt of a second dissection channel.

Fluoroscopy of the thorax is of little help in differential diagnosis. When a dilated arch and descending aorta are seen due to dissection, they usually show decreased pulsations but such variation occurs that little reliance can be placed on the observation.

Contrast angiography offers the most precise method of diagnosis and delineation of the dissection. Aneurysms in general result in *widening* of a vascular channel, either focal or diffuse; dissection, however, causes a narrow lumen, due to displacement by the false lumen or hematoma. The false channel is not often seen during angiography unless a catheter is introduced directly into it for the injection of radiocontrast medium. Even when the injection catheter is positioned well above the superior intimal tear, the secondary lumen frequently does not opacify because of the small proportion of flow within its walls.

For a dissection involving the total length of the aorta, the most frequent picture is of a rather dilated ascending aorta with narrowing in the arch and descending portions. The normal side of the narrowed aorta is smooth, with clear-cut regular branches—the affected side is irregular, poorly defined, and has inadequate filling of the intercostal and lumbar arteries in particular, and frequently other major branches (renal, mesenteric, splenic, testicular). Here again, one may see a double shadow: the portion which does not fill with contrast material represents the size of the false channel, which is frequently wrapped around the true lumen.

When the dissection begins in the arch or in the descending aorta, a sudden constriction in the true lumen may be seen at the superior end of the hematoma. Both ends of the false passageway may be tapered, but correlation of this with the sites of intimal tearing is poor, unless dye can be seen to pass from one channel to another. This may be aided by using rapid film changing techniques or cineangiography. A short area of dissection may only be recognized by a localized or diffuse thickening of the aortic wall, and many of the smaller areas are probably not seen at all.

The best angiograms are made when contrast material is injected directly into the aorta near the area of intimal tear, where there is communication with the false channel. For this purpose femoral or brachial arteriotomy is desirable, with introduction of a No. 7 or No. 8 closed-tip catheter with side perforations. If an open-tip catheter is used, it is best to inject against the stream of flow to produce maximal turbulence and local mixing, and to avoid streamline flow of the injected material. Depending on the size of the patient, 30 to 50 cc. of contrast material* is given by rapid pressure-injection to produce an intraluminal bolus of opaque material. Films are made during injection and for three to four seconds afterward. More than one injection may be made if desirable.

Greenspan and associates point out that using the femoral artery carries a risk of creating additional difficulties in a vessel which may already be involved in the dissecting process.[7] They advocate the use of intravenous aortography. This admittedly safer technique must be weighed against the poorer films obtained.

Translumbar aortography has also been used in the past to opacify the aorta. Bobbitt, Figley, and Wolfman have reported a high series of complications using this technique.[8] Of 425 studies, 42 had intramural injection of dye, causing death in three subjects. Aortic dissection occurred in two of these patients, surrounding

*We have used Renovist, obtained from Squibb & Sons, E.R., New York 22, New York, with few side effects.

and occluding the renal arteries. Suspicion of an already weakened aortic media should be an absolute contraindication to the translumbar aortic puncture method.

SUMMARY

Aortic dissection has been shown to occur in various clinical syndromes, although its common mechanism is degeneration of the media. Congenital causes are by far the most frequent, as in the Marfan syndrome and in Erdheim's idiopathic medionecrosis. Arteriosclerosis is an uncommon cause. Hypertension and pregnancy have an increased incidence of dissection. The clinical features most commonly resemble acute myocardial infarction, but may be differentiated by physical signs, the electrocardiogram, and by radiography. Angiographic confirmation and delineation of the area of dissection has been shown to be increasingly important as the possibility for corrective surgery becomes more widely known and available.

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Child Psychiatry

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Systemic Use of Fibrinolytic Agents

(Continued from Page 490)

IN SUMMARY, fibrinolytic therapy may ultimately have some value in the treatment of carefully selected patients with thromboembolic disease. Further developments in this area, however, depend in large part upon further research on the biochemistry and pharmacology and standardization of these agents, development of simple techniques for the monitoring of *in vivo* fibrinolytic effect and the establishment of *objective* criteria to be used in well-controlled clinical studies of the benefits of such enzymatic therapy in specific forms of thrombotic disease. Until such a program has been instituted and the results assessed the routine clinical use of commercially available fibrinolytic agents is, in our opinion, not justified.

MSMS Centennial Series:

1940—MSMS Diamond Jubilee

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D, Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

The year 1940 was an important one in the history of the Michigan State Medical Society. It marked the "Diamond Jubilee" of the Society.

At the Annual Meeting in Detroit on September 25-27, registration hit a new record with 2,561 persons registered, including 1,813 members of the Society.

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AT THE Diamond Jubilee, 149 members received "Certificates of Associate Fellowship in Postgraduate Education" for completed courses sponsored by the MSMS Postgraduate Committee.

Michigan Medical Service, which was started in 1939, continued to require considerable attention. On November 30, 1939, The Council transferred the task of inaugurating the Medical Service Plan to the Board of Directors of the Michigan Medical Service. In January, 1940, the organization sent out Registration Applications to all doctors of medicine in Michigan to signify their desire to cooperate in providing medical services for persons in the low income group on a pre-payment basis. As of June 6, 1940, 3,082 doctors had completed their applications to the Michigan Medical Service. As of July 31, 66,982 persons were enrolled, including employees and usually their dependents. An average of 1,700 subscribers each month had been noted.



Burton R. Corbus, M.D.
MSMS President, 1939-40

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THE COMMITTEE on Industrial Hygiene of the MSMS had produced the following program:

1. To make a survey of the facilities now in existence to meet the problem of industrial health.
2. Concentration of our effort upon the development of an appropriate educational program.
3. Cooperation with the official health agencies in acquainting the medical profession with the laws with reference to reporting of occupational diseases.
4. After the profession is prepared by these programs, local committees on industrial health should be appointed, whose function it will be to study their own local problems and cooperate with the official health agencies to promote health and hygiene methods in the control of occupational diseases.

Seven Michigan Health Departments received awards in 1939 in the National Health Conservation Contest. Highest honors went to the Alger-Schoolcraft Health Department, which was awarded first place among rural health departments in the northeastern division.

A series of 24 weekly radio programs were presented over a network of 12 stations during the period from November 6, 1939 to May 10, 1940.

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ONE OF THE MOST noteworthy programs of the Preventive Medicine Committee was completed in 1939 resulting in the distribution of immunization schedules and cards. These cards were mailed to the parents of all new-born children and to be kept as a permanent record of that infant's health from birth to the day he enters school. The parent was advised when to see his family doctor for protection against whooping cough, diphtheria and smallpox.

Dues of the MSMS had not been raised but remained at $12 per annum. The Council was authorized by the House of Delegates to levy an assessment of $5 per member to cover emergencies. However, financial matters were so well arranged that no direct assessment or increase in dues was necessary.

Among other matters of importance was the upholding by the Wayne County Circuit Court of the Constitutionality of Michigan's Basic Science Law, passed by the Legislature in 1937.

The reader can easily see that it was a busy year for Doctor Corbus and his official family.



The Author
WILLIAM J.
STAPLETON, JR., M.D.
MSMS Historian

Men From 90 Countries Trained in United States

Elsewhere in this issue is a report on internships of our Michigan medical graduates. It is of interest to consider as well that, in 1962-63, 7,257 physicians from 90 countries were in training in the United States; 5,840 were residents and 1,417 were interns. They trained in hospitals in 43 states, the District of Columbia, Puerto Rico and the Canal Zone.

Leading countries from which physicians came:

		Number
1.	Philippine Islands	1,687
2.	Canada	574
3.	Iran	535
4.	India	385
5.	Turkey	316
6.	Mexico	250
7.	Cuba	221
8.	Argentina	193
9.	China	186
10.	Colombia	184

Ten hospitals with 50 or more foreign physicians:

1.	Bellevue Hospital Center, N. Y.	73
2.	Boston City Hospital, Boston, Mass.	68
3.	Henry Ford Hospital, Detroit, Mich.	64
4.	Kings County Hospital Center, Brooklyn, N. Y.	62
5.	Washington Hospital Center, Washington, D. C.	61
6.	Memorial Hospital for Cancer & Allied Diseases, N. Y.	58
7.	University of Minnesota Hospitals, Minneapolis, Minn.	57
8.	Mount Sinai Hospital, Chicago, Ill.	57
9.	Jersey City Medical Center, Jersey City, N. J.	50
10.	Michael Reese Hospital, Chicago, Ill.	50

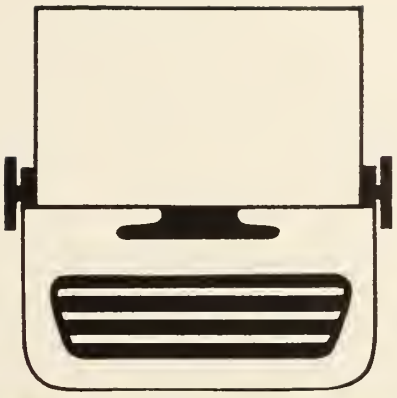
This information is made available to us from "Open Doors 1963" an annual survey conducted by the Institute of International Education.

Once again, it appears that Michigan is making a major contribution.

Are We?

"Are we as individuals doing enough to repay our society, our profession or our community for the way in which we have been received? As in any other thing—be it home, church, or profession—we receive in proportion to what we give."

—F. Mansel Dunn, M.D., President
Ingham County Medical Society
Ingham Medicine, May, 1964



EDITORIAL VIEWS

Explains Relationship Of Occupational Physician And Employee's Own Physician

By MSMS Occupational Health Committee

The laws of Michigan, and all the other states, require employers to supply medical care for employees whose illness or injury arises in the course of their employment. To accomplish these tasks and to maintain a healthful environment and safe working conditions, occupational health programs and physicians to direct them are a necessity. Liberal judicial interpretations of benefit programs and precedent setting decisions have increased the medical liabilities of employers, even though the acts were not intended to make the employer a guarantor of health. Employers do not willingly enter the domain of medical private practice.

In addition to advice on strictly medical matters, the employer needs physician assistance in the areas of planning, insurance, compensation, safety, industrial hygiene, supervision of the medical department, and in the general broad fields of preventive medicine and health education.

The Council of Occupational Health of the American Medical Association has defined the

proper sphere of occupational medicine in the handbook, "Scope, Objectives and Functions of Occupational Health Programs," publication No. 213, revised in 1960. If the handbook recommendations are followed, there should be no competition or conflict of interest between physicians in private practice and those engaged in occupational medicine.

Physicians in occupational medicine do not ordinarily perform medical services that are in the province of the personal physician, but refer the patient to his doctor. All employees are encouraged to choose a personal physician if they have not already done so.

Professional cooperation and improved communications between private practitioners and those in industry are mutually desirable and are needed for the best interests of worker patients. Both adhere to the same standards of professional conduct and medical ethics. Private practitioners are urged to consult the plant physician for information and assistance regarding their patients who are employees. The plant physician needs to consult with and refer to the employee's physician when a worker's medical problems impair his employment. The personal physician may well have information regarding the patient's employability and health problems unknown to the plant physician. The latter has a knowledge of the work requirements and job selection with which the personal physician is not familiar.

The exchange of information may solve difficult problems and create better understanding for the worker and the physicians.

The plant physician needs the help of the personal physician in reducing the excessive absenteeism and unwarranted allegations of illness or injury occasioned by work. The personal physician expects his patients to be given thoughtful consideration and employment that will not endanger health or safety. Both physicians wish to avoid misunderstandings or careless statements that might impair their professional standing and dignity in the eyes of the patient.

Specific information, not vague generalities, should be exchanged. Letters need to be discreet and factual. Where forms are required for the benefit of the patient, these should be completed accurately. Prolonged medical treatment, rehabilitation, or similar problems require a mutual understanding as to the course of action.

The occupational physician and the personal physician operating as a team can do much to keep the employee safely and gainfully employed and contribute to the patient's acceptance of work as one of our most important privileges.

Good Man for Tough Job

Detroit Free Press, May 5, 1964

"Michigan's headache-producing efforts to deal effectively with the troubles of its mentally ill are, hopefully, starting to get relief.

"The appointment by Gov. Romney of Dr. Robert A. Kimmich as director of the Michigan Department of Mental Health should provide long-needed therapy.

"The appointment was overdue. The director's position has been vacant for 16 months. The Legislature's dollar-foolish cut last year in the salary recommended by the Governor contributed to the delay. It reversed itself this year by raising the director's salary from $24,000 to $30,000.

Dr. Kimmich says he is attracted to Michigan's top mental health job as much by the challenge as by the cash. There's plenty of challenge.

"The mental health program in every state faces the job of providing new, intensive treatment with limited state and local budgets.

"In the past, Michigan has answered this challenge more often with charges than cures—charges that the Legislature was hamstringing mental health with inadequate budgets and charges of inefficiency and lack of direction within the department.

"Dr. Kimmich's job will be to find cures.

"His background equips him to use what should be one of Michigan's most effective weapons against mental illness—the Community Mental Health Act passed last year by the Legislature.

"The new program is patterned after California's local clinics. Dr. Kimmich, who is leaving a post as director of San Francisco's community mental health services, knows how such joint state-local programs can work.

"The community centers will be just part of his responsibility. As mental health director, Dr. Kimmich will be responsible for 64 State mental health agencies, including 17 hospitals and 21 child guidance centers.

"He will supervise the spending of some $90 million in State funds and the care given some 34,500 patients.

"It's an awesome responsibility. We wish Dr. Kimmich the best of luck."

Medical Profession Offers Aid

Here's the Latest News

These four colored pages carry late-breaking news in a new MSMS effort to improve its communication with every member.

The late deadline will permit MICHIGAN MEDICINE each month to provide up-to-the-minute information about Society activities, ancillary groups, et al.

As a further improvement, a MICHIGAN MEDICINE news supplement will be mailed on the 15th of each month to every member.

Your comments will be welcomed.

DELEGATION WELL ORGANIZED AT SAN FRANCISCO

MSMS Suite Busy at AMA

SAN FRANCISCO, JUNE 24—The Michigan delegates here for the AMA Convention have been busy attending meetings, conferring with other delegates on common concerns—and extending warm Michigan hospitality.

The MSMS Headquarters Suite at the Fairmont Hotel has been one of the most colorful of the entire convention. MSMS delegates have taken their turns as hosts—and report that visiting delegates are very anxious to obtain a model Michigan-made automobile. All three of the major Michigan auto manufacturers—Chrysler, Ford and General Motors—provided model cars in current design and in snappy colors.

The suite has been attractive with colorful blankets from the University of Michigan, Wayne State University, and Michigan State University. Photos, sketches and other symbolic decorations also helped tell the story of expanding medical-training facilities on Michigan campuses.

A special alumni reception was sponsored by the University of Michigan in the MSMS suite.

The MSMS delegation met May 20 back in East Lansing with Chairman William A. Hyland, M.D., and developed detailed plans for activities here. Hosting schedules were developed, resolutions studied, and assignments made to special AMA meetings. Michigan has been represented at such special events as the Conference on Physicians' Personal Economic Planning, the U. S. Committee on World Medical Association and a Conference on Nursing.

In addition to the MSMS Delegates to the AMA House of Delegates, many other Michigan physicians have been here to attend scientific activities and allied events. Wives also have been prominent in the activities of the Woman's Auxiliary meeting here.

A more complete story will appear in the next issue of MICHIGAN MEDICINE.

On June 15, nearly 7,000 Michigan service stations began offering a voluntary automobile safety check program to help reduce traffic accidents this summer.

The target is at least 1,500,000 safety-checked cars before the peak of the summer season.

The program is coordinated by the Associated Petroleum Industries of Michigan.

Mental Health Congress Held In Detroit

DETROIT, JUNE 26—"The medical profession stands ready, and is able, to provide guidance and medical direction to community leaders as they proceed to mobilize the resources of their communities to attack mental health problems."

So stated Benjamin Jeffries, M.D., Detroit, at the "Congress on Mental Illness and Health" held today in Detroit by the Michigan State Medical Society.



DR. JEFFRIES

Doctor Jeffries is chairman of the MSMS Mental Health Committee and a member of the Michigan Mental Health Advisory Council.

The Congress, which featured prominent speakers and lively discussion groups, was opened by Doctor Jeffries. He told the physicians and interested lay people about the great need for effective community mental health programs.

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DURING THE AFTERNOON, the participants divided into 13 discussion groups with qualified MSMS members as leaders.

Edward H. Rodda, M.D., Bay City, Program Chairman for the Congress, presided at the final general assembly when the discussion groups reported back.

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The recommendations will provide the basis for follow-through work by the Michigan State Medical Society and will

Continued on Page 501

Honor Jones on UP Tour

The first swing in several years through the Upper Peninsula in Mid-June by representatives of the Michigan State Medical Society took on added importance this year.

The four representatives—Orlen J. Johnson, M.D., President; Louis F. Hayes, M.D., Vice Speaker of the House of Delegates; Hugh W. Brenneman, executive director, and M. A. Riley, legislative-public relations field secretary—took part in a special program at Menominee.

At Menominee, the MSMS visitors joined with many others to honor William S. Jones, Sr., M.D., for his many years of "valued service to the health of the people of Michigan and Wisconsin" and for his outstanding leadership in the state society. Doctor Jones served effectively as a MSMS President and more recently as Chairman of the Big Look Committee, which directed the new-headquarters project.

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A PLAQUE FROM MSMS was presented by President Johnson and a Letter of Appreciation was read from Harold H. Hiscock, M.D., as Chairman of The MSMS Council. The members of Menominee - Marinette County Medical Societies joined together to also present a plaque. Leaders of several county medical societies in the Upper Peninsula also attended. Jean Worth, former Menominee editor and now editor at Escanaba, was the master of ceremonies for the fine dinner meeting at the Riverside Country Club with the wives as special guests.

MSMS Councilors D. Roemer Smith, M.D., Iron Mountain, and James R. Dehlin, M.D., Gladstone, attended. Many of the details for the event were directed by John R. Heidenreich, M.D., Daggett, and R. C. Olson, M.D., Menominee County Medical Society secretary.

It was an interesting sidelight that the county society plaque was signed by William S. Jones, Jr., M.D., son of the honored doctor. The son is now president



WILLIAM S. JONES, SR., M.D.

of the Menominee County Medical Society, another position that his father formerly filled.

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THE MSMS DELEGATION made its first stop June 9 at Sault Ste. Marie to confer with members of the Chippewa-Mackinac society. Several hours later, they stopped at the Newberry State Hospital to visit with the members of the Luce County society.

The same evening, the MSMS leaders talked to the Marquette-Alger society meeting at Marquette.

The Delta-Schoolcraft society was the next stop at Escanaba, where the four men presented a special radio program over the Escanaba station.

Next on the tour was the Menominee meeting June 10 and then lunch the next day with the Dickinson-Iron men at Iron Mountain. That evening, they spoke to the Gogebic society at Ironwood.

The last stop was the Upper Peninsula Medical Society meeting at Houghton. In addition to seeing most of the Houghton-Baraga-Keweenaw doctors there, the MSMS leaders also conferred there with the Ontonagon society members.

MSMS officials report enthusiasm was on a high level across the entire Upper Peninsula and attendance extremely good.

UP Medics Cite Levin, Huron; Elect Bennett

HOUGHTON, JUNE 13—Matthew C. Bennett, M.D., Marquette, was chosen here at the annual meeting of the Upper Peninsula Medical Society, June 11-12-13, to serve as President of the Society for the coming year. He will succeed A. M. Roche, M.D., Calumet.

Among the other highlights at the annual session was a tribute paid to Simon Levin, M.D., who has practiced in Houghton County for the past 63 years. Alfred LaBine, M.D., Houghton, expressed the appreciation to Doctor Levin, who was just recently retired from active practice.

Willis H. Huron, M.D., a former MSMS Councilor from Iron Mountain, received an award from Michigan Medical Service for his many years of service on the Blue Shield board. The presentation was made by Sidney Adler, M.D., Detroit, MMS President.

Orlen J. Johnson, M.D., MSMS President, who was on a swing through the Upper Peninsula with other MSMS representatives, was an honored guest and gave a short address.

(Note: More complete information from the Upper Peninsula Medical Society meeting will appear in the August issue of MICHIGAN MEDICINE.)

Brother and sister, Louis and Antonia Sacchettis, were graduated from the University of Michigan Medical School and have started internships in California. The brother-sister team—a rarity—happened because Louis finished three years in the air force before entering med school.

Antonia is interning in San Francisco, and Louis near Fairfield.

The proud parents are Mr. and Mrs. Louis Sacchettis, Sr., of Iron Mountain.

Rehabilitation, Topic For TV on July 12

Rehabilitation will be the subject July 12 for the MAP "Decisions" television program with Joseph N. Schaeffer, M.D., Detroit, over WJBK-TV at 12:30 p.m.

Doctors of medicine continued to be featured often on both of the MAP television programs. Recent guests on the weekly Detroit program included James D. Fryfogle, M.D., Detroit, on "Engineering in Medicine," and William E. Rush, M.D., St. Clair Shores, on "Diabetes Summer Camp."

The MAP "Formula" program over WJIM-TV in Lansing at 8:30 p.m., Wednesday, offered Paul W. Gikas and Donald F. Huelke, M.D., both of Ann Arbor, on "Formula for Death," June 24. They discussed their investigations of auto fatalities in Washtenaw County.

Continued:

MENTAL HEALTH CONGRESS

be reported to the American Medical Association.

Much of the success of this MSMS Congress was due to the efforts of four men who presented major addresses. They were James G. Miller, M.D., Ann Arbor, Director, Psychiatric Research Institute; Harold M. Visotsky, M.D., Director, State of Illinois Department of Mental Health; Marvin E. Perkins, M.D., Commissioner of Mental Health Services for New York City; and Mike Gorman, Executive Director, National Committee Against Mental Illness, Washington, D. C.

Doctor Jeffries wishes to thank the members of the Woman's Auxiliary to the Wayne County Medical Society for serving as recorders and hostesses. Appreciation also is voiced to the AMA-Smith, Kline & French Laboratories Grant Fund.

Participating with MSMS in the Congress was the Michigan Society of Neurology and Psychiatry, Michigan District Branch of the American Psychiatric Association; and also the Michigan Society for Mental Health.

(*Note:* See next MICHIGAN MEDICINE for more detailed reports.)

Are You Member Of M.D. PAC?

George Anthony, M.D., of Flint, reports the Genesee County membership campaign for M.D. PAC-AMPAC went over 100 members on June 15.

M.D. PAC and AMPAC are organized by physicians to give you an effective coordinated campaign for political education and candidate support.

Your check for $25 or more to M.D. PAC, Box 169, East Lansing, will make you a member of both state and national organizations.

Bring Together Doctors, Newsmen

The series of meetings, started last year, is being continued in Michigan to bring newsmen from press, radio and television together with leaders of county societies and MSMS to improve relationships.

Concerns voiced by both groups are discussed and plans are always started to further improve cooperative ventures. Each of the news media dinners has resulted in better rapport and better liaison.

The meetings follow a similar pattern. After a short social hour, the men sit down for dinner and informal discussion. Leaders of the county society and MSMS then make short presentations to set the stage for questions and answers.

Newsmen and doctors, who have participated in such meetings, have all enthusiastically endorsed the project as important and worthwhile.

Any interested county medical society seeking assistance to present such a program is invited to get in touch with the MSMS headquarters. MSMS staff personnel will assist with the arrangements.

As newsmen and physicians finished their dinner at the MSMS Headquarters, the program details for the Ingham Media Dinner in June were checked out by F. Mansel Dunn, M.D. (standing left), President of the Ingham County Medical Society, and Oliver B. McGillicuddy, M.D., MSMS President-Elect (standing right).



Begin Community Health Week Plans

The Michigan Association of the Professions and the Michigan Health Council have been invited by The Council of the Michigan State Medical Society to share in the planning and observance of Community Health Week in Michigan.

The AMA has set the week for October 18-24.

Goal of Community Health Week will be to urge every citizen to become more familiar with present community health resources and to work with fellow citizens in studying and planning any additional health facilities or programs to meet the health needs of the future.

Each county medical society is urged to appoint a special chairman now for Community Health Week to expedite its planning and observance.

Educational efforts also will urge Michigan residents to secure a family doctor, obtain available immunizations, emergency medical identification cards and signal devices, avoid throwing money away on quacks and quack products and to assist the Michigan Health Council in its efforts to recruit students into health professions.

Plans are under way to hold several open houses in Michigan hospitals, rehabilitation institutions, nursing homes and other medical facilities in an effort to give students interested in exploring careers in health, as well as their parents and counselors, an opportunity to see the health team in action. During the 1964 celebration, the Michigan Health Council will give special emphasis to physical therapy and other careers in rehabilitation.

Walter Seegers, M.D., Grosse Pointe, has been named as the first holder of a new "Chair in Haematology" at the Wayne State University School of Medicine.

Orthopaedic Meeting Set; LaFerte Honored

The annual meeting of the Michigan Orthopaedic Society will be held at the University Club in Detroit, Wednesday evening, September 23, according to Hira A. Branch, M.D., Flint, President.

The organization recently held its summer meeting at Hidden Valley where A. D. LaFerte, M.D., Detroit, was honored. Dr. Branch presided at the meeting one day, with Angus Goetz, M.D., Detroit, presiding the other day.

R. W. Pomeroy, M.D., Lansing, is MOS Secretary-Treasurer, and Curtis M. Hanson, M.D., Kalamazoo, is President-Elect.

Snake Bite Article Among Papers Slated For August Reading

Snake bite death is rare in Michigan but non-fatal bites are not uncommon in the southern one-half of Lower Michigan. The August issue of Michigan Medicine features an original, unpublished manuscript entitled "Massasauga Bites in Michigan" which should be of interest to all of us.

A well-illustrated review of methods of repair of Common Finger Tip Injuries is also present in the issue, as are a philosophic reflection on the Therapeutic Use of the Placebo, a review of the extent and scope of health service protection in the United States today, and other articles, as well.

Invite Nominees For H/D Awards

The 55 component county medical societies are invited to nominate one or more members for consideration for "MSMS Certificates of Commendation."

Suggestions are sought by W. L. Brosius, M.D., Chairman of the MSMS House of Delegates Committee on Certificates of Commendation. Possible names and biographies should be sent before July 15 to Doctor Brosius, c/o MSMS, Box 152, East Lansing.

The House of Delegates established this award in 1961 after it had voted to abolish the former "Foremost Family Physician Award."

Winners of MSMS Certificates of Commendation in 1963 were the following:

Forest D. Dodrill, M.D., Bloomfield Hills
Charles J. Jentgen, M.D., Detroit (now deceased)
John M. Sheldon, M.D., Ann Arbor
Homer H. Stryker, M.D., Kalamazoo

Winners of MSMS Certificates in 1962 were the following:

Jerome W. Conn, M.D., Ann Arbor
J. D. Cummings, M.D., Lansing
Charles S. Kennedy, M.D., Detroit
Robert L. Novy, M.D., Detroit

Under a new Peace Corps policy, volunteer physicians will be allowed to take their families with them to overseas posts. Wives of physicians will not be required to serve as volunteers although they must complete a Peace Corps application for information purposes.

Doctors with children can be accepted and adequate family living allowances will be provided.

Detailed information about specific programs and Volunteer Questionnaires may be obtained from Office of Public Affairs, Peace Corps, Washington, D. C. 20525.

BLOCK OUT DATES, SEPT. 23–25, NOW FOR ANNUAL SESSION

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See Pages 504-5 for Program Details

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Every Michigan doctor is urged today to block out his office calendar so he can attend the Michigan State Medical Society 99th Annual Session in Detroit, September 23-24-25.

The House of Delegates meeting will be held September 20-21-22 and will be followed with the scientific session as in the past.

All the activities will be at the Sheraton-Cadillac Hotel.

The 1964 meeting will take on added excitement as the state medical society moves toward its big Centennial activities. The 100th Annual Session will be held in Detroit in September of 1965, and a spectacular Health Fair is planned for Cobo Hall, Detroit, April 30-May 8, 1966.

Because MSMS was started in Detroit, the annual meetings will be held there two years in a row, and move back to Grand Rapids for 1966. Normally, the meetings alternate between the two cities.

The 1964 highlight will be the Annual MSMS Dinner Dance, on Thursday night, September 24, with U. S. Congressman Gerald R. Ford, Jr., as the speaker this year.

Congressman Ford, who represents the Fifth Congressional District of Kent and Ottawa counties, is chairman of the House Republican Conference Committee, a member of the House Appropriations Committee, and often mentioned as a potential vice-presidential nominee.

The House of Delegates registration will begin at 6:00, Sunday night, September 20, with the first session slated that night for 8:00. The House will continue in session Monday, September 21, and Tuesday, September 22.

Interested MSMS members may attend the House of Delegates sessions and reference committee meetings as guests.

The program for the Annual Scientific Session, September 23-24-25, will begin each morning at 9:00. The educational program will continue until 5:30 p.m. on September 23 and 24, and until 12:30 p.m. on Friday, September 25.

Once again, following the successful 1963 Scientific Session in Grand Rapids, the Program Committee has obtained outstanding speakers for panel programs.

Harry A. Towsley, M.D., Ann Arbor, chairman of the planning committee, is extremely enthusiastic about the subjects and speakers selected for 1964.

As in the past, no registration fee for members of MSMS and other state medical associations, AMA and the Canadian Medical Association, will be charged. The registration personnel on the fourth floor of the Sheraton-Cadillac will ask registrants to show their membership card.

More information about the 1964 Annual Session will appear in the August and September JOURNALS.

Remember, block out your office calendar today so you can join your conferees in Detroit, September 23-24-25.

Calendar of Events

July 30-31—Coller-Penberthy Medical Conference, Park Place Motor Inn, Traverse City

September 20-25—Michigan State Medical Society House of Delegates and Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit

September 22-24—Woman's Auxiliary to MSMS Annual Meeting, Pick-Fort Shelby Hotel, Detroit

September 23-24—Michigan State Medical Assistants Society Annual Meeting, Statler-Hilton Hotel, Detroit

October 15-17—University of Michigan Medical Center Alumni Conference, Ann Arbor

WSU Cites Doctor Owen

Clarence I. Owen, M.D., Detroit, Past President of MSMS, received an Alumni Citation at the 96th Annual Wayne State University Alumni Reunion. A graduate of 1920, Doctor Owen is a past president also of the WSU Medical Alumni Association and vice-president of the WSU Alumni Association.

OUR STATE SOCIETY



Wednesday-Thursday-Friday, September 23-24-25

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

9:00 A.M. to 5:30 P.M., Wednesday and Thursday

9:00 A.M. to 12:30 P.M., Friday

Scientific Assembly Program For MSMS Annual Session

Wednesday, September 23

A.M.

9:00 to 10:30 — Panel Presentation on "CURRENT PERSPECTIVES IN PANCREATIC DISORDERS"

Moderator: Joseph A. Rinaldo, Jr., M.D., Associate Physician, Division of Gastroenterology, Henry Ford Hospital, Detroit

Panelists:

Internist: Howard F. Raskin, M.D., Head, Division of Gastroenterology, University of Maryland, Department of Medicine, Baltimore

Pediatrician: Harry Shwachman, M.D., Boston, Mass.

Surgeon: Kenneth W. Warren, M.D., Boston, Mass.

Radiologist: Klaus Ranniger, M.D., Associate Professor of Radiology, University of Chicago Clinics

11:30 to 12:30 — Panel Presentation on "SHOCK"

Moderator: Allan P. Thal, M.D., Chairman, Surgery Department, Wayne State University

Panelists:

Surgeon: Richard C. Lillehei, M.D., Associate Professor of Surgery, University of Minnesota Medical School

Internist: Max H. Weil, M.D., Associate Professor of Medicine, University of Southern California School of Medicine

Internist: Robert P. Gilbert, M.D., Evanston, Ill.

P.M.

2:00 to 3:15 — Clinical Pathological Conference on "MATERNAL DEATHS"

Moderator: William W. Jack, M.D., Grand Rapids

Panelists:

Anesthesiologist: Virginia Apgar, M.D., Director, Division of Congenital Malformations, The National Foundation, New York City

Obstetrician: J. Robert Willson, M.D., Chairman, Department of Obstetrics and Gynecology, Ann Arbor

Pathologist: A. James French, M.D., Professor of Pathology, Ann Arbor

Internist: John M. Weller, M.D., Professor of Internal Medicine, Ann Arbor

4:15 to 5:30 — Panel Presentation on "TRENDS IN DIAGNOSIS AND TREATMENT OF ALLERGIC DISEASES"

Moderator: James A. McLean, M.D., Associate Professor of Internal Medicine, Ann Arbor

Panelists:

Allergist and Internist: Paul M. Seebohm, M.D., Professor of Internal Medicine, State University of Iowa, Iowa City

Allergist: Carl E. Arbesman, M.D., Associate Clinical Professor of Medicine and Assistant Clinical Professor of Immunology, Buffalo Medical School, New York

Pediatrician: George B. Logan, M.D., Rochester, Minn.

Thursday, September 24

A.M.

9:00 to 10:30 — Panel Presentation on "CANCER OF THE HEAD AND NECK"

Sponsored by the Michigan Cancer Coordinating Committee

Moderator: Walter P. Work, M.D., Professor of Otorhinolaryngology, Ann Arbor

Panelists:

Otolaryngologist: John J. Conley, M.D., Pack Medical Group, New York City

General Surgeon: Oliver H. Beahrs, M.D., Surgical Section, Mayo Clinic, Rochester, Minn.

Radiologist: Franz J. Buschke, M.D., Professor of Radiology, Department of Radiology, School of Medicine, University of California, San Francisco

Pathologist: David A. Wood, M.D., Director, Cancer Research Institute, School of Medicine, University of California, San Francisco

11:30 to 12:30 Panel Presentation on "HEADACHES"

Moderator: Russell N. DeJong, M.D., Professor of Neurology, Ann Arbor

Panelists:

Psychiatry-Neurology: Arnold P. Friedman, M.D., Headache Unit, Montifiore Hospital, New York City

Internist: John R. Graham, M.D., Director, The Faulkner Hospital, Boston, Mass.

Psychiatrist: Raymond W. Waggoner, M.D., Ann Arbor

Now's the Time— Get Your Art Entry Ready for '64 Show

The summer months may provide the extra hours so doctors and their wives can create paintings, prints, sculpture and crafts for the 1964 Art Exhibit.

The exhibit by Michigan doctors and their wives will take place September 22, 23, 24 in the Sheraton Cadillac Hotel, in conjunction with the annual meetings of MSMS and its Woman's Auxiliary.

Similar exhibits the last three years have proved to be most successful, and it is hoped that this year's show will evoke an even larger response from the Michigan artist doctors and their wives, declares Mrs. L. Jerome Fink, Bloomfield Hills, Art Show chairman.

Awards will be given in the following categories:

Class I—Paintings including oil, encaustic lacquer, polymer, etc.

Class II—Paintings including watercolor, casein, tempera, gouache.

Class III—Sculpture all media.

Class IV—Ceramics.

Class V—Drawing and graphic art, including all print techniques.

Class VI—Three dimensional design: weaving.

Any additional information may be secured from the chairman of the Art Exhibit. Write to Mrs. L. Jerome Fink, 4430 Quarton Road, Bloomfield Hills.

P.M.

2:00 to 3:00 Panel on "GENESIS AND SEQUELAE OF AN AUTOMOBILE ACCIDENT"

Moderator: Paul W. Gikas, M.D., Ann Arbor

Panelists:

Automotive Engineering: Roy Haeusler, Safety Engineer at Chrysler Corp., Detroit

General Surgeon: Horace E. Campbell, M.D., Denver, Colorado

Internist: Harold Brandaleone, M.D., New York City

4:00 to 5:30 Panel on "THE RECOGNITION AND MANAGEMENT OF CERTAIN HEREDITARY DISEASES"

Moderator: Harold F. Falls, M.D., Ann Arbor

Panelists:

Geneticist: Margery W. Shaw, M.D., Associate Professor of Human Genetics, Ann Arbor (Chromosomal)

Pediatrician: David Hsia, M.D., Chicago, Ill. (Metabolics)

Geneticist: F. Clarke Fraser, M.D., McGill University, Montreal, Canada (Phenocopies)

Dermatologist: Thomas Butterworth, M.D., Reading, Pa. (Dermatological diseases)

Internist: Richard M. Goodman, M.D., Assistant Professor of Medicine, Ohio State University, Columbus, Ohio

Friday, September 25

A.M.

9:00 to 10:15 Panel presentation on "SKIN MANIFESTATIONS OF SYSTEMIC DISEASE"

Moderator: John R. Haserick, M.D., Department of Dermatology, Cleveland Clinic, Cleveland, Ohio

Panelists:

Pathologist: John T. Headington, M.D., Assistant Professor of Pathology, Ann Arbor

Dermatologist: Arthur C. Curtis, M.D., Professor of Dermatology, Ann Arbor

Internist: Ray W. Gifford, Jr., M.D., Cleveland Clinic, Cleveland, Ohio

11:15 to 12:30 Clinical Conference on "SOME COMMON ENDOCRINE DISORDERS"

Moderator: Raymond C. Mellinger, M.D., Detroit

Panelists:

Internist: George J. Hamwi, M.D., Professor of Medicine, Ohio State University College of Medicine

Pediatrician: Lytt I. Gardner, M.D., Syracuse, N. Y.

Obstetrician: A. E. Rakoff, M.D., Professor of Gynecologic Endocrinology, Philadelphia, Pa.

Muskegon Contributes to PTA

The Muskegon County Medical Society, which had a profit of $32,000 after paying for oral vaccine and other expenses, contributed the money to the PTA Council there. The Council will redistribute the money to the various neighborhood PTA units which participated in the project. The Muskegon project reached 80 per cent of the population.

Wayne Elects Officers

Francis P. Rhoades, M.D., was selected as President-Elect of the Wayne County Medical Society in its spring election. Other 1964-65 officers include Wyman C. C. Cole, Sr., M.D., President; Louis E. Heideman, M.D., Secretary; Edward M. Vardon, M.D., Trustee, five-year term; Brock E. Brush, M.D., Trustee, one-year term. Doctor Cole succeeds Alfred H. Whittaker, M.D., who served as President of the Wayne County Medical Society for 1963-64.



COUNTY SOCIETIES

Jackson Wants 30 Physicians Soon

The Jackson County Medical Society has launched a recruitment program aimed at getting 30 new physicians to enter practice in the county within the next ten years.

Andrew K. Payne, M.D., and Joseph A. Preston, M.D., are directing the effort, which is built around an informational and personal-contact program.

The Jackson County Medical Society bases its estimate of needing another 30 physicians in the county within 10 years on a combination of projected population growth and increased need.

Expectant Couples Forum at Midland

The Midland County Medical Society and the Visiting Nurse Association completed a series of eight weekly classes for expectant couples. Midland physicians served as speakers.

Kalamazoo Holds Sports Workshop

The Kalamazoo Academy of Medicine recently cooperated with the Western Michigan University department of physical education and athletics to present a "Preventative Sports Medicine Workshop" on the campus. Resource persons included Robert Bailey, M.D., Ann Arbor, and the following Kalamazoo physicians—Robert Hume, Curtis Hansen and Richard Lemmer.

Most Ingham MD's Use Seat Belts

At least 75 per cent of the doctors in Ingham County Medical Society, who have seat belts installed in their automobiles, always use them—or use them most of the time.

According to an informal survey conducted through the return postcards, 84 per cent of the doctors have seat belts. The survey was requested by the Public Health Committee, which has taken an active interest in the use of seat belts in its traffic safety activities.

Saginaw Honors Young Scholars

The Saginaw County Medical Society recently held its annual reception to honor outstanding high school graduates of Saginaw area schools. The young scholars and their parents were invited to the special event at the Amerwood Inn. Donald F. Woomer, M.D., and Thomas P. Mahaney, M.D., were in charge of the fine youth project.

St. Clair Joins Heart Forum

The St. Clair County Medical Society joined with the United Community Chest and Michigan Heart Association and the Port Huron *Times-Herald* to offer a Community Heart Forum. St. Clair doctors on the program included Ezra V. Bridge, M.D., Harold E. Fulton, M.D., and Arthur B. Yull, M.D.

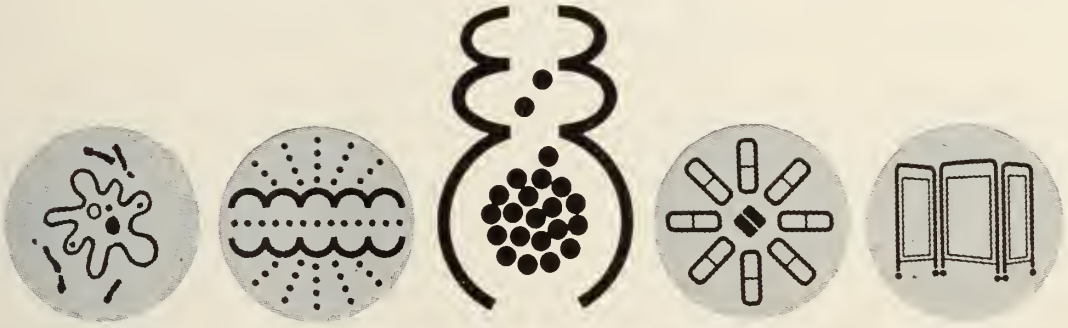
Joint Meeting Held at Traverse City

The Tri-County Medical Society and the Traverse City Pharmacist Association recently joined for a meeting to hear an official of Parke, Davis & Company, who pointed out that the average American family spends proportionately less of its income for drugs today than it did 10 years ago.

in virtually all diarrheas...prompt symptomatic control

LOMOTIL®

TABLETS / LIQUID—Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with inpaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

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In obesity, "...our drug of choice has been methedrine (methamphetamine hydrochloride)... because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West. J. Surg. **59**:238 (May) 1951.

Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

Dosage: 2.5 mg. (½ tablet) 3 times daily. May be increased gradually according to response; more than 10 mg. daily rarely is needed. The last dose of the day should not be taken later than 6 hours before bedtime.

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

Supplied: Tablets 5 mg., scored, in bottles of 100 and 1000.

Complete literature available on request from Professional Services Dept. PML.

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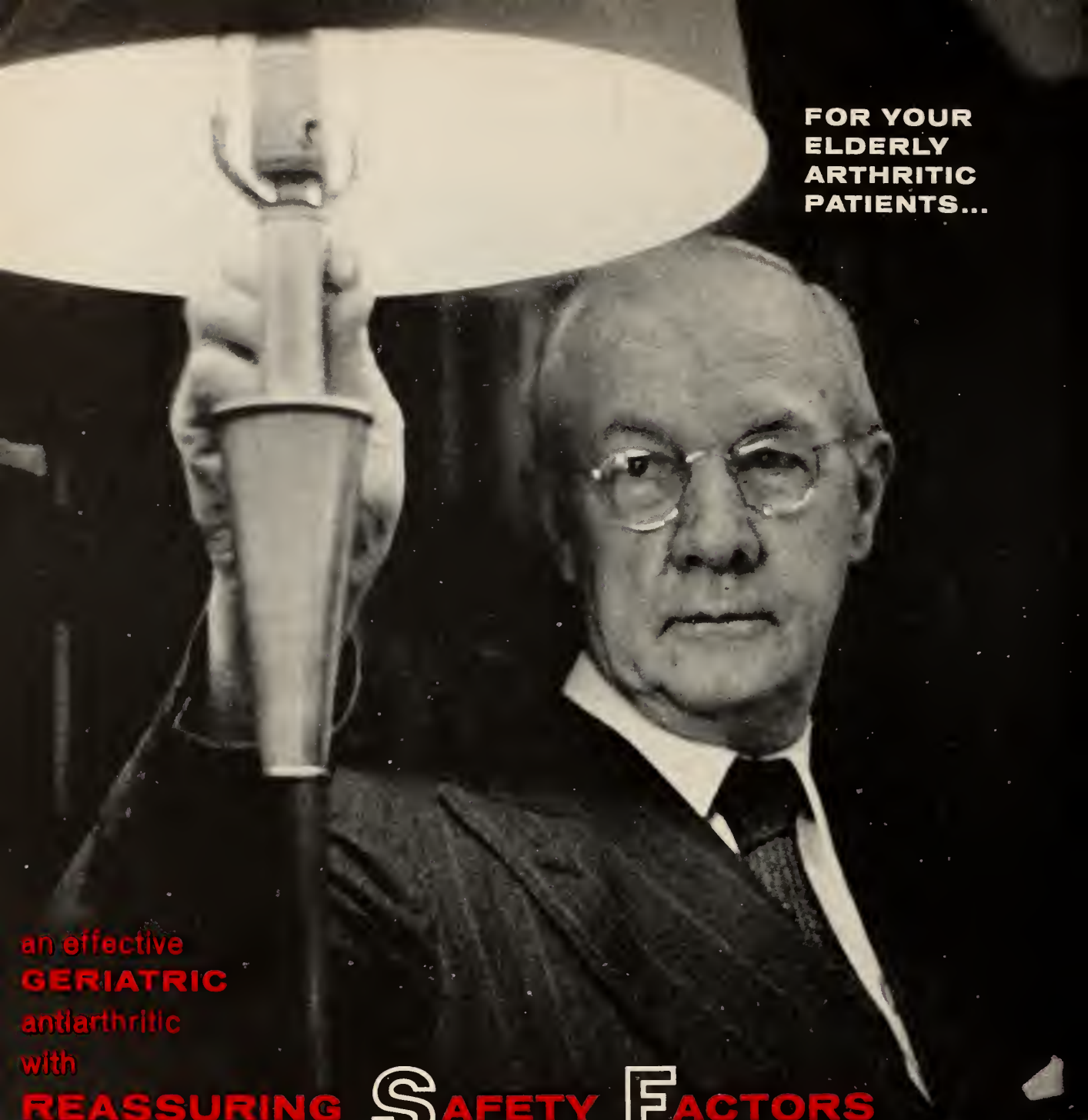
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Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

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"Bringing the Hospital Home"

BY SIDNEY E. CHAPIN, M.D., DEARBORN

The Detroit Metropolitan area now has a new 250-bed hospital. This hospital has no address or telephone number. Each of the patients is in his own bed at home!

Among these patients there are many with heart disease and strokes; many are in the various stages of cancer; some have sustained hip fractures or other orthopedic conditions; there are many diabetics, some with complications, and there are many patients with various neurological conditions. Rheumatic fever, rheumatoid and osteoarthritis, postoperative convalescents, complicated maternity problems, and other diagnoses are also represented.

These patients were discharged, earlier than would be expected, from 12 selected hospitals and some are eligible for care at home in this program regardless of hospital, if they belong to a particular industrial group.

Blue Cross is reimbursing the Visiting Nurse Association for the cost of the care of these patients.

Under the supervision of the private physician, each patient is visited regularly by a visiting nurse from the Detroit Visiting Nurse Association. Many of these patients have had a dietary and nutrition consultation in their homes. Some have been seen by a physiotherapist or occupational therapist. Many have special equipment on loan from various community agencies. Drugs, dressings and other supplies have been provided for these patients through the hospital from which they were discharged. Laboratory studies and x-rays have been provided as though they were in the hospital. Blue Cross has assisted many of these patients by paying 50 per cent of the cost of a homemaker aide, a trained individual to help the patient at home. In addition, a program of family education in the care of the patient has been instituted.



SOCIO-ECONOMIC

In Albion, Traverse City, Howell, Port Huron, Lansing, and Saginaw, similar home care "hospitals" are growing.

In the past 30 years, the tendency has been to build hospitals and construct more beds in the attempt to provide facilities for the care of the sick. This has been found to be exhorbitantly expensive as a device for meeting the needs of the sick.

In an intensive care unit, it is estimated that the cost for a patient is about $60 per day. When the patient moves into intermediate care, the average hospital care, the cost is about $40 per day. In minimum care units, utilizing the self-help principle, the cost is about $22 per day. In the continuation zone for the long-term convalescent patient, the estimated cost is about $15 per day.

It is only when the patient is moved out of the hospital atmosphere into a home care program that real economies can be achieved. When talking about home care programs, one is talking about the difference between a $40-per-day cost per patient and a $7-per-visit cost per patient. Home care programs, when their cost is projected on a per-day basis, reach such figures as $3.50 to $4.00 per day.

While the indigent and aged are often the recipients of these services, they are not necessarily the only persons who can benefit. It can be applied to any person regardless of type of illness, age, or financial status. Home care services offer a new way to provide extensive medical care for many patients at a lesser cost.

The modern hospital has become a very complex, highly-specialized diagnostic and therapeutic facility. Because of profound changes in our social and cultural patterns, as well as for the more obvious economic and health reasons, the cost of hospital care has become expensive and the cost continues to rise.

Hence a program that costs one-sixth as much with no capital investment, is a boon to

(Continued on Page 513)

Doctor Chapin is Medical Director, Detroit Visiting Nurse Association Home Care Program.

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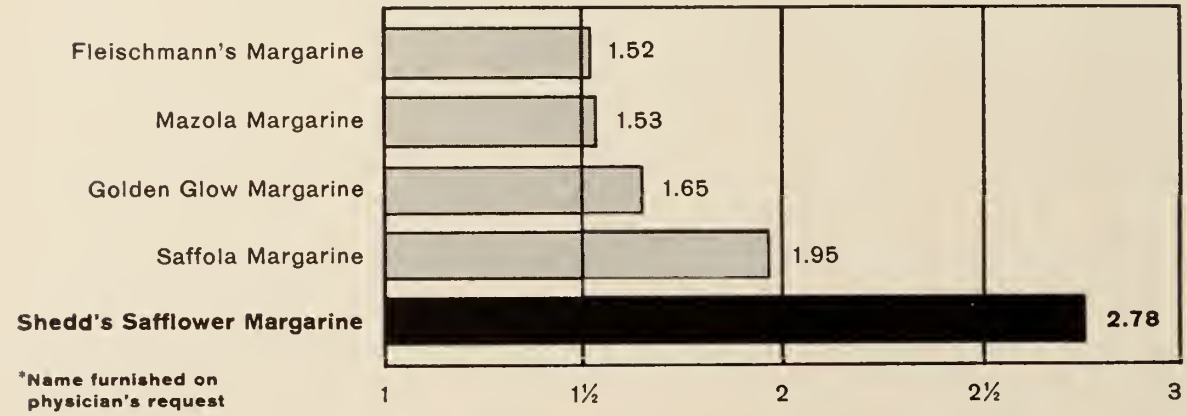


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THE RESULTS OF THIS TEST PROVED SHEDD'S SAFFLOWER MARGARINE HAS A HIGHER RATIO OF POLY-UNSATURATES TO SATURATED FATS.



*Name furnished on physician's request

Shedd's Safflower Margarine Tastes Best, too!

NOTE TO DOCTORS: For free physician's certificates just send your request to Shedd-Bartush Foods, Inc., Detroit 38, Mich., on your Rx form.

Say you saw it in Michigan Medicine

(Continued from Page 511)

the individual patient and to the community that must foot the bill.

A coordinated home care program provides continuity of services between the hospital and the establishment of a comparable regime at home.

A good home care program gets the patient out of the institutional atmosphere in which he becomes the prisoner of his bed because he has no place to go.

A good home care program provides the enlivening surroundings of home which strengthen the patient's will to get well.

A good home care program is a rehabilitative project, aimed at marshalling community resources for physical and psychological retraining of the chronically-ill.

A good home care program evaluates the patient in terms of his own potentialities, and provides the services required for achieving goals—this being the basis for good rehabilitation. Each patient is considered an individual, regardless of age, and the program is tailored to his individual requirements.

A coordinated home care program reduces the number of days of hospitalization necessary for selected patients. It provides a more efficient rotation of the existing hospital beds. It postpones the day when huge capital investment will be necessary to increase hospital facilities to meet the demands of an increasing population.

Of course, the private physician, in each case, must agree that home care is feasible for his patient. The home environment must be a good one. The family must be agreeable to assist in the care of the patient. The patient must want to be at home.

The private physician's orders are passed on to the agency supervising the home care program. Then a nurse is assigned to the case, she visits the home, sees the patient, and establishes needs and objectives for the patient.

Drugs and dressings and other supplies are obtained from the hospital on the private physician's prescription. The various therapies are also provided according to the doctor's orders.

The goals of rehabilitation, even in a hospital, are mainly directed toward the patient's functioning in a home environment. At least the last phases of any successful rehabilitation program should take place at home.

Physicians unfamiliar with the capabilities of the home setting are always surprised at the rehabilitative goals that can be achieved through a coordinated home care program. Home care has been the role of practicing physicians and public health nurses for a long time. However, organization of these services in an administrative structure now described as "coordinated home care" is rather new.

This type of medical care is not second best, and it is not "cut rate." It provides the best of modern medical care, makes it possible for the chronically-ill to be looked after in their own homes, and provides them with the wide range of professional services which are not easily secured through the physician alone.

Dr. Cecil Sheps makes the point that home care is respectable, but it is not yet fashionable. In Detroit, the coordinated home care program is now not only respectable, but quite fashionable.

In conclusion, the new and growing interest in home care programs is not looked upon as a substitute for hospital care, but should be considered as part of the total medical care plan which can best meet the needs of certain patients in certain phases of their illness.

Some 20 per cent of general hospital beds are occupied by persons who could be cared for effectively and more economically in a home setting.

The solution to the cost and care problem cannot be found merely in progressive expansion of beds and additional facilities in hospitals, nursing homes or other institutions. The costs of new hospital construction are high, maintenance of hospital facilities is expensive and rising, and other institutional facilities are not always available. Furthermore, institutionalization for long periods results in losses in personal satisfaction, initiative and creativity.

In looking for an alternate solution, coordinated home care, the systematic provision of medical, nursing, social and related services to patients in their homes, could be the answer.

NOTE: Health services in the home are becoming more frequently prescribed as a method of alleviating the strain on overtaxed hospital facilities.

At its March 4th meeting, the MSMS Committee on Medical Socio-Economics reviewed and analyzed

"A Report of the First Year of Operation Michigan Hospital Service-Visiting Nurse Association Home Care Project."

This special article by Sidney Chapin, M.D., a member of this Committee, is intended to point up the possibilities of home care, especially the economic advantages—R. M. CAMPAU, MSMS Research Director

Offer Smoking Pamphlet

Interested doctors may obtain copies from the AMA of a new pamphlet, "Smoking: Facts You Should Know," for a small charge. The pamphlet is offered as part of the AMA campaign to inform young people on health hazards of tobacco. Such an educational drive was adopted at the AMA annual meeting in 1963. One copy is available for five cents and 100 for $1.50. Address orders to AMA, 535 N. Dearborn Street, Chicago, 60610.

For the "modern Cinderella"

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"...No other disease has caused so much feeling of inferiority" as acne.[1] pHisoHex "...is a valuable part of the management...since in addition to its defatting and cleansing properties, it offers an antibacterial action which reduces skin bacterial flora."[2]

In a series of 42 patients, none "...failed to improve," when pHisoHex was added for the wash.[3] In another series of 67, acne lesions "...cleared in a matter of one to two weeks" in 50 per cent with pHisoHex.[4] In another series of 100 patients using pHisoHex and pHisoAc®, 79 showed excellent or good improvement.[2]

The frequent exclusive use of pHisoHex enhances adsorption of its 3% hexachlorophene content to the skin; there it remains as a tenacious film to fight bacteria *between* washings. pHisoHex cleans thoroughly—is nonalkaline, hypoallergenic and "kind" to the skin. Three to four washings a day are needed for constant degerming of skin, faster and better results.

pHisoAc Cream dries, peels and masks lesions—helps prevent comedones, pustules and scarring. Contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent and hexachlorophene 0.3 per cent.

How supplied: pHisoHex is available in unbreakable squeeze bottles of 5 oz. and 1 pint, in unbreakable plastic bottles of 1 gallon and in combination package with pHisoAc Cream.

References: **1.** Szymanski, F. J.: *Indust. Med.* 30:498, Nov., 1961. **2.** Wexler, Louis: *Clin. Med.* 70:404, Feb., 1963. **3.** Hodges, F. T.: *GP* 14:86, Nov., 1956. **4.** McLean, I. E. D.; Graham, K. T., and East, M. O.: *Practitioner* 189:82, July, 1962.

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(1888-M)

Say you saw it in Michigan Medicine



Congratulations are extended by Jacob F. Wenzel, M.D., Detroit, outgoing Medical Alumni Association president, to William J. Stapleton, Jr., M.D., upon his Distinguished Service Award.



The new president, Hugh W. Henderson, M.D., Detroit, greets alumni following his installation.

WSU Medical School Honors Doctor Stapleton

William J. Stapleton, Jr., M.D., Detroit, MSMS historian, has a "Wayne State University Distinguished Service Award" to add to his collection of deserved citations. The presentation was one of the highlights of the 96th annual alumni reunion of the WSU School of Medicine Alumni Association.

The citation honors Doctor Stapleton "in grateful recognition of his untiring devotion and meritorious service to the WSU School of Medicine."

Hugh W. Henderson, M.D., Detroit, was installed as the new Alumni Association president, succeeding Jacob F. Wenzel, M.D., Detroit. The banquet program also included comments by Dean Ernest D. Gardner, M.D., and Gordon H. Scott, Ph.D., WSU Vice-President, recognition of the Class of 1914, and the presentation of several honorary membership awards and alumni awards to medical students.

Others taking office at the 96th Alumni Clinical Program were Drs. Marion W. Jocz, Grosse Pointe; and Frank Walker, Grosse Pointe; president-elect, and secretary, respectively.

Out-going officers are Drs. Jacob F. Wenzel, Grosse Pointe, who served as president; and Niles Schwocho, Allen Park, secretary.

Medical student awards went to:

James Andre, St. Clair Shores, who received the A. Ashley Rousuck Award in Internal Medicine.

Myron Eisenman, Detroit, the Senior Alumni Scholarship Award.

Kenneth Gitlin, Detroit, the Junior Scholarship Award in Surgery for work he did last year.

Evelyn Fisher, Detroit, the Alumni Scholarship Award given each year to a second-year student.

Kahn, Usndek to Lead Detroit Dermatological Society

Harold Usndek, M.D., Detroit, was chosen as president-elect at the annual meeting of the Detroit Dermatological Society.

David Kahn, M.D., Lansing, was installed as the new president. Serving also with him will be Robert Schoenfield, M.D., Birmingham, secretary-treasurer, and Harold Plotnick, M.D., Detroit, recorder.



ANCILLARY SECTION





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Comparable to the Mantoux in accuracy and sensitivity, the TUBERCULIN, TINE TEST is now available in plastic-capped units uniquely suited to general practice needs. They are so simple to use that you can test every patient with ease. Since it requires no refrigeration, the new package of five Tine Test units can stand on any convenient table in your examining rooms, ready for routine use. Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis.

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Say you saw it in Michigan Medicine

COLLER-PENBERTHY CONFERENCE, JULY 30-31 OFFERS AUTHORITIES ON VARIED SUBJECTS

Outstanding medical authorities from Ohio, Missouri, Florida, Connecticut, Nebraska and Michigan will address the Coller-Penberthy Medical Conference at Traverse City, July 30-31.

General Chairman Frank H. Power, M.D., Traverse City, predicts that the 44th annual conference will be one of the best. He adds that special events will include a golf tournament and the annual banquet July 30 with State Senator William G. Millikin as the speaker.

Following is the list of speakers and topics:

"Iatrogenic Staphylococcal Enterocolitis," William A. Altemeier, M.D., University of Cincinnati; "Surgical Treatment of Thrombo Embolism," Marion S. DeWeese, M.D., University of Missouri; "The Pathogenesis and Treatment of Acute Dilatation of the Stomach and Paralytic Ileus," Lester R. Dragstedt, M.D., University of Florida; "A Rational Use of Prophylactic Antibiotics in Surgical Practice," Mark A. Hayes, M.D., Yale University; "More on Colloids, Cuts and Clots," Merle M. Musselman, M.D., University of Nebraska.

From the University of Michigan School of Medicine—"Esophageal Varices," C. Gardner Child, III, M.D.; "The Battered Child Syndrome," Harry A. Towsley, M.D.; "Some Urological Problems in Children," Reed M. Nesbit, M.D.; "Data Storage and Retrieval in Radio Therapy," Isadore Lampe, M.D.; "The Present-Day Treatment of Tic Douloureux," Edgar Kahn, M.D.; "Television Fluoroscopy," Fred J. Hodges, M.D.; "Quiz," A. James French, M.D.; "Some of the Common Virus Infections of the Skin," Arthur C. Curtis, M.D.; and "Common Disabilities of the Foot," Carl E. Badgley, M.D.

From Wayne State University School of Medicine—"Transplantation of the Heart," Richard J. Bing, M.D.; "An Evaluation of the Surgical Treatment of Hirschsprung's Disease in Infants and Children," Clifford D. Benson, M.D.; "Serum Enzymes and Their Use in Clinical Medicine," Joseph W. Hess, M.D.; "Atypical Pneumonia," G. Thomas McKean, M.D.; "Observations on the Use of Antithyroid Drugs, 20 Years' Experience," William S. Reveno, M.D.

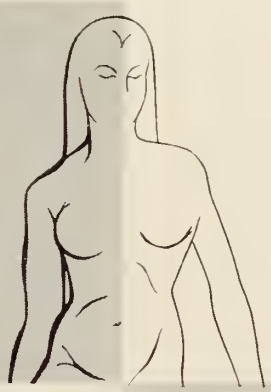
Another Ann Arbor speaker will be Donald R. Korst, M.D., on "Chemotherapy of Cancer, the Importance of Selection of the Patient."

Other speakers will include William N. Hubbard, M.D., Dean School of Medicine, University of Michigan; A. C. Furstenberg, M.D., U-M Dean Emeritus; Orlen J. Johnson, M.D., MSMS President, and John M. Sheldon, M.D., U-M Director of the Postgraduate Medicine.

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little C. N. S.** stimulation

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levamfetamine succinate 21 mg.
(Releasing the drug over a 6-10 hour period)

Each **CYDRIL** (levamfetamine succinate) Tablet contains:
levamfetamine succinate 7 mg.

Side Effects: Rare—C.N.S.** stimulation minimal, occasionally cardiovascular and gastrointestinal reaction may be observed.
Contraindications: Severe hypertension, angina pectoris, hyperthyroidism and Raynauds disease.

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Request clinical samples and literature on your letterhead.

*Granucaps—T.M. Reg. U.S. Pat. Off.

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DETROIT 34, MICH.

Kimmich on Job as New Mental Health Director

Robert A. Kimmich, M.D., began duties July 1, as the new director of the Michigan Department of Mental Health.

He was appointed in May by Governor Romney after the position had been vacant 16 months.

To come to Michigan, Doctor Kimmich left a position as director of San Francisco's community mental health services. Here he will be responsible for 64 state mental health agencies, including mental hospitals and child guidance centers.

John B. Deiter, Ph.D., director of Washington state's northwest hospital-community program, has been named an assistant director of the Michigan Department of Mental Health and will head the planning division.

Also appointed to the top planning staff is Philip D. Smith, M.D., who will serve as associate director of the division under Dr. Deiter. Dr. Smith, a psychiatrist, is clinical director of psychiatry at Northern State Hospital, Sedro Woolley, Washington.

Wayne SAMA Picks Leader

The Student American Medical Association at Wayne State University has selected Henry M. Taylor, Dearborn Heights, as president for the coming year. Other officers will be selected in the fall.

U-M SAMA Elects

James Roberts of Allen Park will serve as president during 1964-65 of the Student American Medical Association at the University of Michigan.

Other officers will include Charles Henry, Kalamazoo, vice-president; Lee DeMeester, Grand Rapids, secretary, and William Pohnert, Whitmore Lake, treasurer.

Industrial Medical Group Advances McIntosh, Magnuson

Members of the Michigan Industrial Medical Association have elected Robert D. McIntosh, M.D., Detroit, as president for 1964-65. Dr. McIntosh is medical director of the Ternstedt Division of General Motors Corporation in Detroit.

He succeeds Henry J. Kreulen, M.D., Grand Rapids.

Harold J. Magnuson, M.D., Ann Arbor, former vice president, was named president-elect. He is director of the Institute of Industrial Health at the University of Michigan.

Martin F. Bruton, M.D., Detroit, was elected vice president. Re-elected secretary-treasurer was Benjamin B. Holder, M.D., Midland. Two new members of the MIMA board were also elected: Francis L. Purcell, M.D., Flint, and Frank G. Talbot, M.D., Detroit.

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ARLIDIN
(NYLIDRIN HCl)
increases blood flow...



IN CEREBROVASCULAR INSUFFICIENCY
where vascular insufficiency may cause such symptoms as mental confusion, diplopia, fatigue, apathy, and behavior problems.



IN PERIPHERAL VASCULAR DISEASES
where ischemia causes muscle distress—pain, spasm, ache, intermittent claudication; also coldness, numbness or ulceration of extremities.

State Health Department Comments on VD Increase

The Michigan Department of Health reports that record shows venereal diseases are still on the increase in Michigan. In 1963 there were 11,043 cases of gonorrhea and 5,512 of syphilis reported in Michigan.

For syphilis this represents a 27% increase over 1962 and a 66% increase over 1961.

For gonorrhea it represents a 6% decrease as compared to 1962 but a 16% increase over 1961. Venereal disease remains a serious public health problem, even though the increase in reported cases may be partly a result of better reporting by private physicians.

At the present time almost one-fourth of reported cases occur among Michigan teenagers and over one-half among those under 25.

The State Health Department points out that "the official responsibility for the control of venereal disease in Michigan is focused in the local health departments but they cannot carry out their function without the whole-hearted cooperation of private practicing physicians."

Field Visitations

As a part of their responsibilities, these field consultants are available to help private physicians throughout the state in obtaining contact information and in the subsequent tracing of named contacts.

Additional objectives of these visits are as follows, according to the State Health Department:

"1. To personally enlist the physician's cooperation in a program to control syphilis and eventually eliminate it as a public health problem.

"2. To inform the physician of the current venereal disease problem on a national, state, and local basis and thereby raise his 'index of suspicion' in looking for syphilis among patients.

"3. To leave with the physician the latest professional material on diagnosis and management of all venereal diseases.

"4. To encourage the physician to report all cases of venereal disease and to permit epidemiologic follow-up by the health department, where indicated.

"5. To inform the physician of the many services that he can obtain from the health department; i.e., diagnostic aids, medical consultation, et cetera."

Laboratory Follow-Up

During the past year over 30,000 reactive serologic tests for syphilis were reported by both private and public laboratories in Michigan. "On a large percentage of these specimens it was neces-

(Continued on Page 522)



IN CIRCULATORY DISORDERS OF THE INNER EAR

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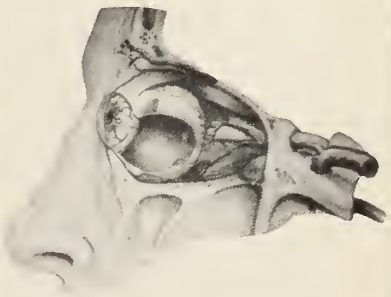
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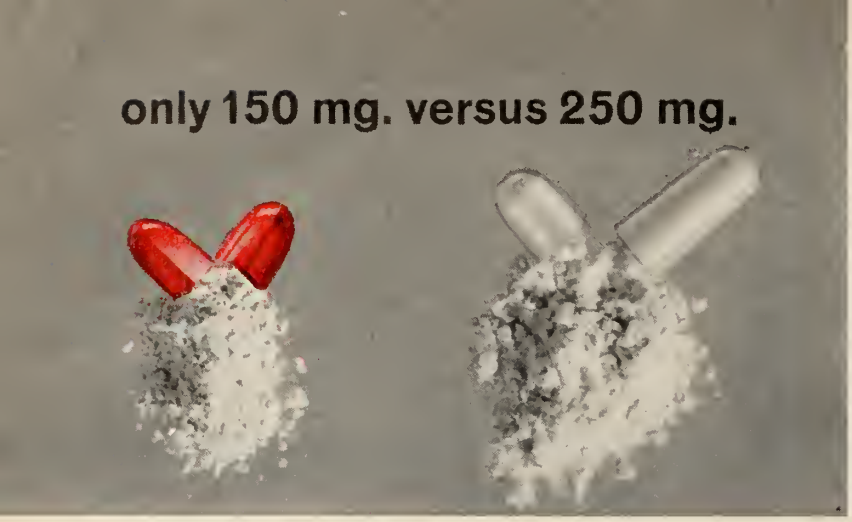
IN CIRCULATORY DISORDERS OF THE EYE

where there is vasospastic and circulatory impairment.

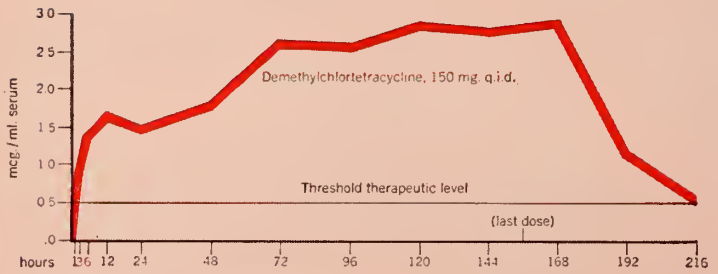
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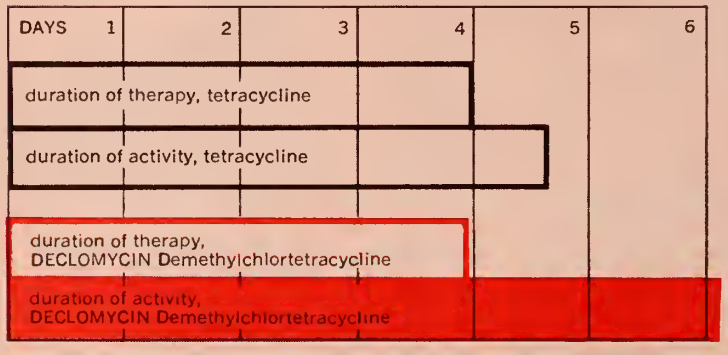


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From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M.: *Amer. J. Med. Sci.* 243 296 (Mar.) 1962.

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(Continued from Page 519)

sary to get in touch with the physician in order to obtain a disposition within a reasonable time period," the State Department declares.

Syphilis Epidemiology

All patients who are reported by health department clinics as having infectious syphilis are interviewed to determine recent sexual contacts. This service is available for all private cases provided permission is given by the physician.

To prevent further spread of the disease, such epidemiologic follow-up must be performed as quickly as possible.

Legislature Honors Doctor Yoder

The Michigan House of Representatives, in its recent session, adopted a resolution honoring Orrus Ray Yoder, M.D., who retired as superintendent of the Ypsilanti State Hospital.

The resolution, introduced by Representatives Upton, Warner and Bursely, read as follows:

"A resolution honoring Orrus Ray Yoder, M.D., a distinguished doctor and servant.

"Whereas, Orrus Ray Yoder, M.D., was born on a farm near Goshen, Indiana, in 1893, attended Goshen Academy and College, where he received his Bachelor of Arts degree in 1916, and, in the same year, became Principal of Middlebury High School in the State of Indiana, where he served in this capacity until he enlisted as a Private in the Regular Army in 1917; he was later transferred to the Medical Reserve Corps and sent to Rush Medical College, where he received his medical degree in 1922, he received his internship at Harper Hospital, Detroit, Michigan; and

"Whereas, Dr. Orrus Ray Yoder has had a long and distinguished career of both public and private service to his city, county and state; he was appointed Assistant Medical Superintendent of Kalamazoo State Hospital in 1922 and transferred to the Ypsilanti State Hospital as Assistant Medical Superintendent in 1931, and was appointed Superintendent of the Ypsilanti State Hospital in 1938; and

"Whereas, Dr. Orrus Ray Yoder was President of the Michigan Society of Neurology and Psychiatry from 1954 to 1955, and is a life member of the Michigan State Society of Neurology and Psychiatry, a Life Fellow of the American Psychiatric Association, a member of the Michigan State Medical Society, the American Medical Society and the Washtenaw County Medical Society, where he has served as its President; now therefore be it

"Resolved, That the members of the House of Representatives feel privileged to pause in their daily tasks to honor and congratulate Dr. Orrus Ray Yoder, M.D., for his life-long record of effective and continuing attainment and service in behalf of his fellow men; and be it further

"Resolved, That a copy of this resolution be transmitted to Dr. Orrus Ray Yoder."



Whether you're a teacher correcting exams. A student cramming for them. A housewife cleaning up after the kids. Or a businessman working late at night. Whoever you are, things go better when you pause and refresh with ice-cold Coca-Cola.

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1. Viglione, J.P.: Clin. Med. *69*:1157 (May) 1962.

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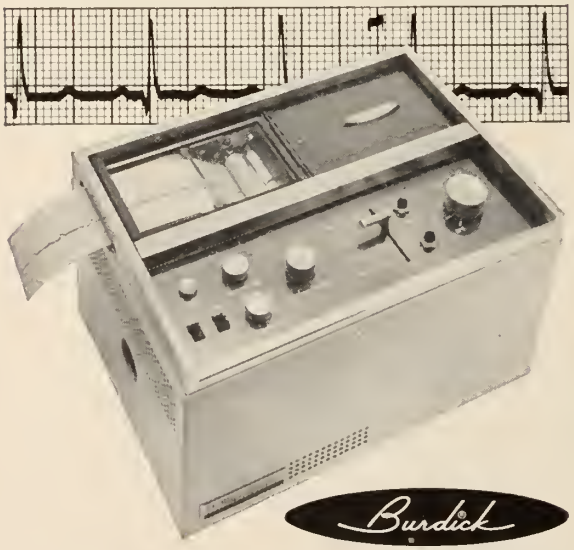
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IN MEMORIAM

James R. Delaney

James R. Delaney, M.D., 55, Detroit physician since 1947, died May 9, 1964.

A graduate of Wayne State University School of Medicine, Doctor Delaney served as a Navy lieutenant commander in World War II. Following his military service, he studied at the University of Pennsylvania before returning to Detroit in 1947. Doctor Delaney taught medicine at Wayne State University in addition to his practice.

He was a past president of the Alumni Association of the University of Detroit.

John B. Glerum

John B. Glerum, M.D., 48, retired Greenville physician and surgeon, died April 25, 1964.

Doctor Glerum received his medical degree in 1943 at Wayne State University School of Medicine, and interned at Blodgett Hospital, Grand Rapids. He served four years in the U. S. Army, attaining the rank of major. He began his practice in Greenville in 1948, retiring in March of 1963 because of illness.

Lynn N. Hershey

Lynn N. Hershey, M.D., 68, Birmingham psychiatrist, died May 7, 1964.

A graduate of University of Kansas Medical School in 1922, he later studied at the University of Pennsylvania, Johns Hopkins University and Queens Square Hospital, London, England. Doctor Hershey was a Detroit area practitioner since the 1920's, and began his practice in Birmingham in 1946.

Memberships included the American Psychiatric Association, Phi Chi medical fraternity and Phi Kappa Psi. He was on the staffs of Beaumont, Pontiac General and Detroit Grace Hospitals.

Edward D. Hunderman

Edward D. Hunderman, M.D., 78, Grand Rapids physician for 52 years, died May 18, 1964.

A graduate of the University of Detroit Medical School, Doctor Hunderman studied in Europe for one year in his specialty of ophthalmology and otolaryngology prior to military service in World War I. He was a Life Member of the Michigan State Medical Society.

Donald C. Somers

Donald C. Somers, M.D., 63, prominent Oakland County orthopedic surgeon, died May 2, 1964.

A 1927 graduate of the Detroit College of Medicine, Doctor Somers studied orthopedic surgery at

Say you saw it in Michigan Medicine

the University of Michigan Medical School. He was on the staffs of Harper, Highland Park General and Beaumont Hospitals, and was a member of the American Academy of Orthopedic Surgeons.

Clarence T. Starker

Clarence T. Starker, M.D., 82, Pontiac physician since 1912, died May 4, 1964.

A 1905 graduate of Wayne State University school of medicine, Doctor Starker practiced in Saginaw and in El Paso, Texas, before beginning his practice in Pontiac.

He was a Life Member of the Michigan State Medical Society.

Robert O. Webster

Robert O. Webster, M.D., 37, Wayne orthopedist, died May 3 following a boating accident.

Doctor Webster was a 1955 graduate of the University of Michigan Medical School. Doctor Webster began his practice in Wayne three years ago, following residencies in Ohio and California. He was on the staffs of seven hospitals in the Detroit area.

Doctor Yoder's Plan to Retire Means Loss to City, State

Ypsilanti Daily Press, May 4, 1964

"The announcement last week of Dr. O. R. Yoder's plans to retire as superintendent of Ypsilanti State Hospital on July 2 can't help leaving you with a sense of loss.



"Few persons in Michigan have become so closely associated with the institution they head; few have done a better job or are more widely respected. This is particularly true here in Ypsilanti itself, where the warmth of his personality and the fine flavor of his humor have won him hundreds of friends and admirers.

"He has been at the hospital since it was founded in 1931 and has been superintendent since 1938. In his tenure it has grown to one of the top institutions of its kind in the country, with 40 wards, 950 employes and more than 4,000 patients.

"It's going to be hard to think of Ypsilanti State Hospital without thinking of Dr. Ray Yoder. His record is its own finest commendation."

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Letters to The Editor:

To the Editor:

This is in reply to a rather heated letter of Dr. Robert Johnston, as appeared on page 388 of the May, 1964, issue of the JOURNAL.

It is the desire of the author of the article, "Excision of Carotid Body for Advanced Emphysema," to convey his experience with the procedure. No mention, nor is the intention stated or implied to suggest that cervical glomectomy should substitute or serve as a definitive treatment for pulmonary emphysema. Reference is made to the article that patients on whom this procedure was performed, have all had the benefit of therapy of proven value, such as antibiotics, bronchodilators et cetera. As we all know, there is no curative treatment for pulmonary emphysema. Palliative improvement of its symptoms of shortness of breath is what the article was concerned with.

Secondly, since disturbances of blood pH O2 and CO2 level are known to exist in patients of advanced pulmonary emphysema, resection of carotid body seems to have as much rationale as in its employment for "Asthmatic" patients. The article did mention the necessity of clearer definition and connotation of the word "asthma." It is not believed, however, that "asthma," meant by Dr. Nakayama and Dr. Overholt, includes the so-called cardiac asthma or asthma due to obstructive lesion, such as foreign body or tumor of lung. In fact Dr. Nakayama arbitrarily set a length of 15 years of bronchial asthma as desirable for consideration of cervical glomectomy. Pulmonary emphysema usually would be present in such patients.

It is hoped that with the aid of a competent surgeon familiar in arterial surgery and anatomy of the neck, that the next patient with advanced pulmonary emphysema, for whom all medical measures have failed to improve his dyspnea, be given a chance to decide whether or not to elect to have this procedure. It is believed that the chances are that both the patient and the physician will be pleasantly surprised. It is also hoped that advances will be made in the understanding of pulmonary emphysema so that neither theoretical nor palliative treatment will be necessary to substitute for a curative treatment.

Sincerely yours,
JOHN L. SHEK

Bay City, Michigan
May 20, 1964

Say you saw it in Michigan Medicine

Dear MSMS Members:

In recent years, front pages of newspapers and magazines have been full of reports of a phenomenon peculiar to the post World War II era of medicine—doctors' strikes. Italy, Japan, a Canadian Province, and more lately, Belgium have all had their share of headlines. Significantly, all of the strikes by doctors in these nations have been caused by objections to government legislation hampering private initiative and the free practice of medicine. And therein lies a warning to every practicing physician in this country.

In Belgium, the representative groups of specialists and the G.P.s were not united and failed to protest the introduction of the Leburton Social Security Act in November, 1962. The Belgian Medical Federation still had not protested the Leburton Act in July, 1963, when, after assurances from the Minister of Health to Belgian doctors that their association would be consulted on implementation of the law, the Belgian Parliament passed the measure. These assurances later proved to be false, paving the way for a doctors' strike due to many objectional features of the law.

In the United States, the American Medical Association is the spearhead of the organized drive to combat socialized medicine. The World Medical Association, of which AMA is a member, continues to work in this direction on an international level. Nationally, AMA's efforts are joined solidly by every leading allied professional medical organization. American doctors are fortunate to have medicine united and working together in this struggle for self-preservation.

Use every opportunity you have to support those who lead your fight nationally and internationally so that the principle of professional freedom in medicine may persevere.

Gerald D. Dorman, M.D.,
Secretary-Treasurer
World Medical Association
New York, New York

Bright Future in Mental Disease Prevention

The keys to the rapid progress we are making in the management of emotional disturbances are the new drugs and the treatment techniques which are at our disposal. We now measure treatment in terms of days, weeks, or months instead of years and decades. These medical advances also mean that the psychiatrist no longer stands alone—all physicians, regardless of specialty, have tools and knowledge enough to diagnose and manage many forms of mental illness. Nor have we yet really touched prevention's great potential.—Millard B. Bethel, M.D., in *Hawaii Medical Journal, Vol. 23, No. 3.*

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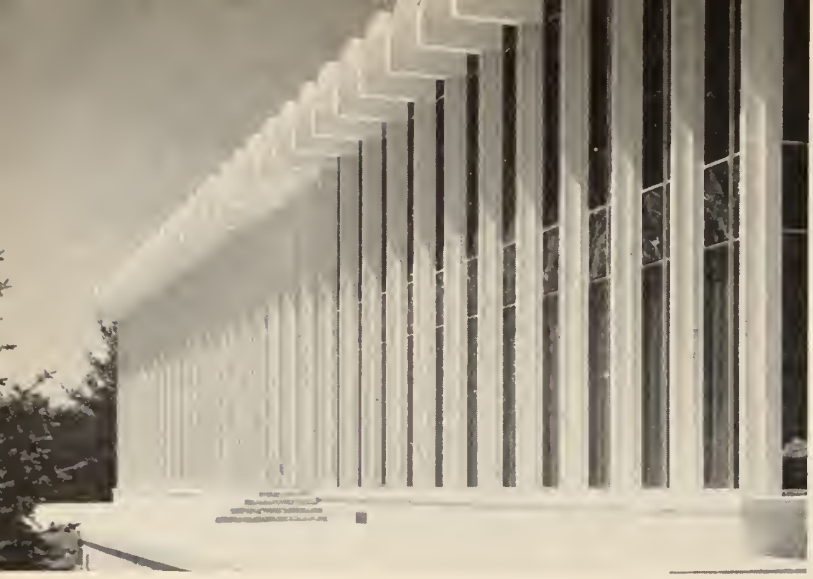
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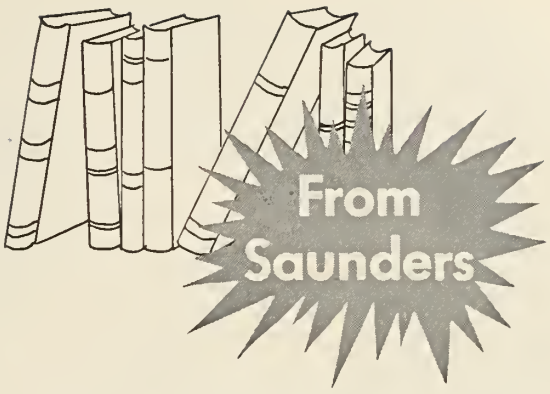
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President's Message

The Boys from Europe

By ORLEN J. JOHNSON, M.D.
MSMS President

Once upon a time in Europe a fellow developed a philosophy of governmental life called "Marxism." Through the years parallel governments of outright socialism and communism and others have evolved. Fascism reached its ultimate rise and fall under the maniacal leadership of Hitler.

The other proponents have been content seemingly to let their pet systems evolve piecemeal under patient adroit leadership and propaganda. In times of stress they have been able to advance rapidly. Lacking real crises they have planted in the minds of the public the need for collective programs under the aegis of government. The subtlety of these programs has inculcated in the minds of apparently sound citizens their reasonableness.



The American public repeatedly rejected socialist candidates—in fact made jest of them. But the cunning ones avoided the hazards of bold attack on all fronts. With wisdom they have taken advantage of temporary needs or crises and established segmental socialistic programs, there is no other name, which have become permanent. With great fluidity they have moved from phase to phase. Knowing that once they have accomplished a coup it was permanent yet alive and gradually more encompassing without effort.

The seemingly sound citizens accepted these developments for other people—yet when they struggle against those affecting their enterprise or lives it is futile. The strong currents, political and economic, have such force they can rarely be stemmed or diverted. There may be temporary surcease by compromise but the principle is lost. Legislation follows the pressure of demands. If this is too slow judiciary action seems to take over legislative function to hasten the inevitable.

Michigan's socialist pressure does not wear that label—yet familiar environment in the party and European training are indelibly obvious. Medicine has been waging an open battle on the obvious frontal attacks—to date—successfully. The protagonists have not been completely thwarted. Some of the programs in medicine which we have accepted—even fostered, may yet more completely engulf the private practice of medicine.



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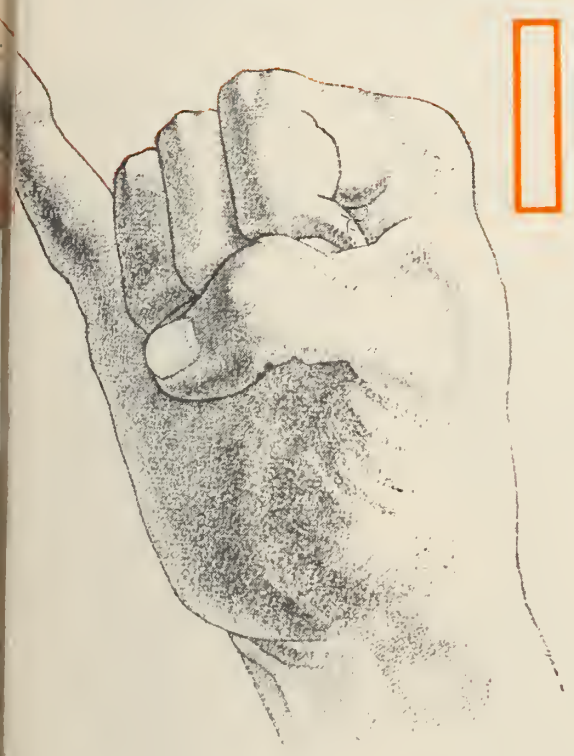
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s with any drug containing prednisone, Arthral- en-PR is contraindicated, or should be adminis- tered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

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*Cohen, et al: J.A.M.A., 165:225, 1957.

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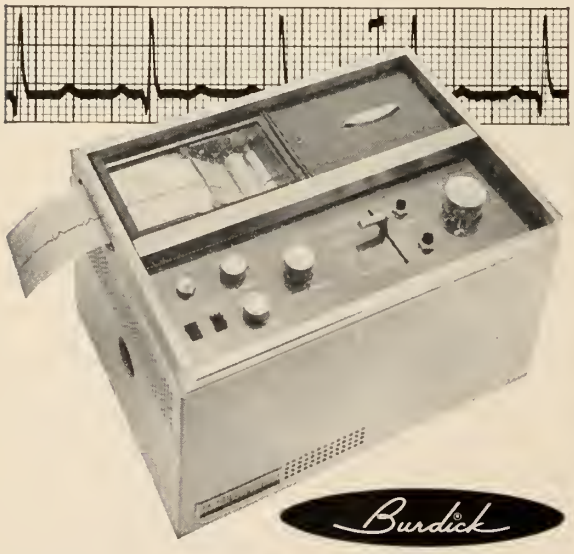
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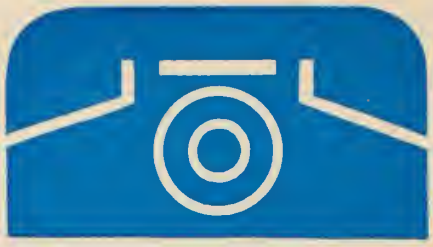
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NEWS BRIEFS

A community recognition banquet July 1 honored **John R. Heidenreich, M.D.**, a member of the MSMS delegation to the AMA, who has completed 25 years of service at Daggett. Tributes were paid by village, school and community officials and also by **W. S. Jones, M.D.**, Menominee, MSMS Past President.

Serving as chairman of the Clinton Township Community Relations Commission is **Rufus Courtney, M.D.**, Mt. Clemens.

A special citation for service to the Michigan School Health Association was awarded to **Oscar D. Stryker, M.D.**, Mt. Clemens. He is a former president of the MSHA, which made the award presentation at its 1964 annual meeting.

The largest farm in Shiawassee County has been purchased by **Leon Fill, M.D.**, Huntington Woods, from Cameron and John Carruthers, of Laingsburg. The farm covers 1,000 acres.

Speakers at the recent annual meeting of the National Tuberculosis Association and the American Thoracic Society in New York City included **E. Osborne Coates, M.D., Geoffrey L. Brinkman M.D.**, and **Benjamin M. Lewis, M.D.**, all three of Detroit.

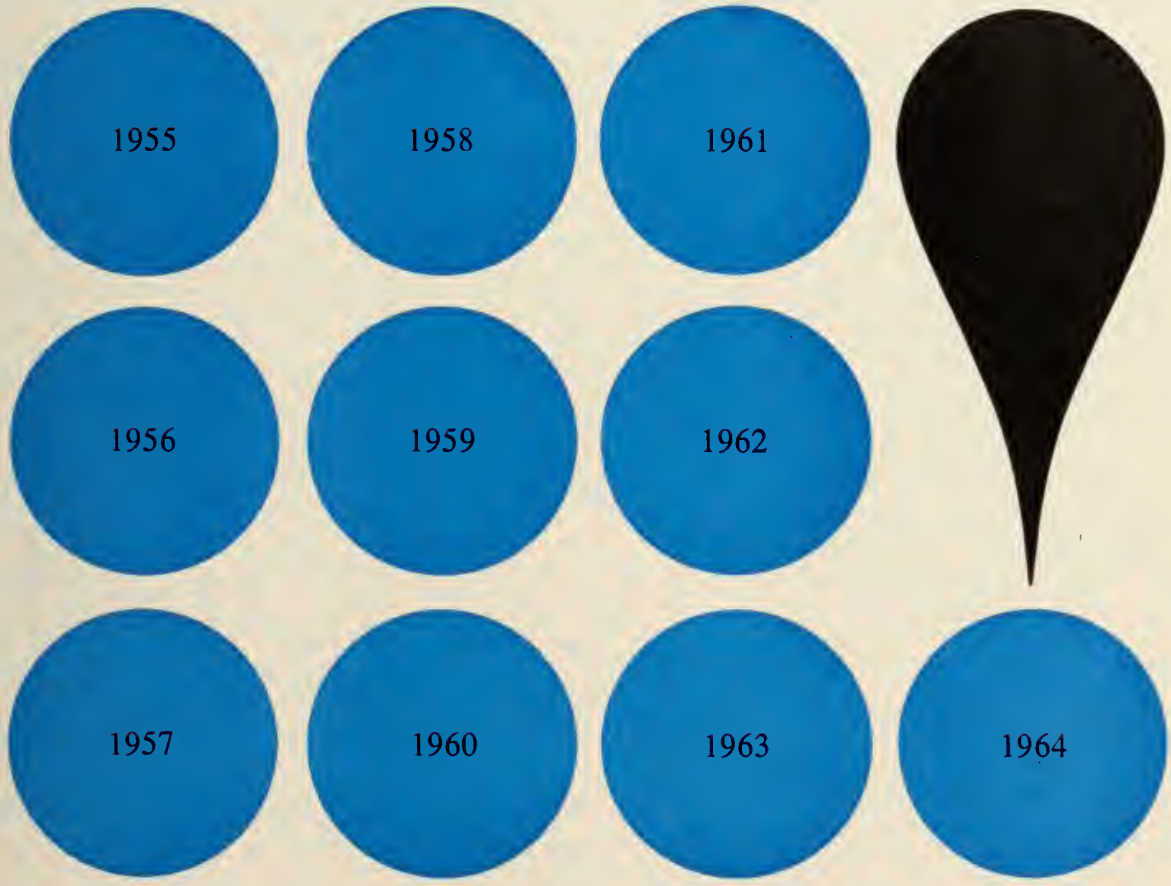
The American Board of Obstetrics and Gynecology reports that the following Michigan doctors have been certified: From Detroit, **Harold M. Rosen, M.D.**; from Grand Rapids, **Louis Helder, M.D.**, and **Harrison C. Visscher, M.D.** From Ann Arbor, **William Rae Forsythe, M.D.**; from Dearborn, **Robert Ross Turner, M.D.**; from Grosse Pointe Farms, **William H. Jevons, M.D.**; from Kalamazoo, **John William Hendrix, M.D.**; from Lansing, **Joseph A. Caruso, M.D.**; from Livonia, **Julio B. Acosta, M.D.**; from Warren, **William A. Starbird, M.D.**; from Wyandotte, **George W. Danz, M.D.**

Raymond J. Dauphinais, director of the Legal Division of the American Pharmaceutical Association, Washington, D. C., has been appointed professor of Pharmacy Administration at Wayne State University. Mr. Dauphinais will assist Dr. Martin Barr, dean of the College of Pharmacy, in administrative measures.

D. Emerick Szilagyi, M.D., Detroit, delivered the 30th annual Edwin A. Jarecki Memorial Lecture at Philadelphia's Albert Einstein Medical Center. He discussed "Surgery of the Abdominal Aorta: The Lessons of Twelve Years."

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Edward Crippen, M.D., at right, formerly of Mancelona, helps with the inspection in Nepal of 100,000 doses of smallpox vaccine from the United States as a contribution of Wyeth Laboratories. Doctor Crippen, now home on leave, has been serving as Chief of the Public Health Division of the Agency for International Development's mission in Kathmandu, Nepal.

President of the Michigan College Health Association is **Robert E. Anderson, M.D.**, Flint, who serves as a consultant for student health at General Motors Institute and as a consultant physician for Flint Junior College.

A paper by **Shattuck W. Hartwell, M.D.**, Muskegon, was presented in Paris before the International Conference on Wound Healing. The Conference was sponsored by the French National Center for Scientific Research.

Leonard Himler, M.D., Ann Arbor, was cited at a special honors banquet by Mercywood Hospital, Ann Arbor, "for his 20 years of faithful dedicated service."

The new president of the Calhoun County Community Council is **Richard J. Campbell, M.D.**, Battle Creek, as past president of the Calhoun County Medical Society.

The Ionia-Montcalm Chapter of the Michigan Society for Mental Health presented a framed certificate to **P. C. Robertson, M.D.**, retired superintendent of the Ionia State Hospital, for his many years of service.

Lula Belle Stewart, M.D., Detroit, has been named "Physician of the Year" by the Detroit Medical Society. The presentation was made by **Charles Wright, M.D.**, Detroit, who received the honor last year.

A paper about "The Use of Computers in Diagnosis of Peripheral Vascular Disease" was given by **James C. Breneman, M.D.**, Galesburg, at the annual meeting of the American College of Angiology at Las Vegas.

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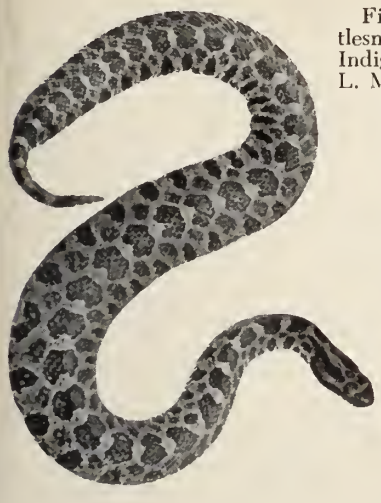


Fig. 1. Eastern Massasauga (Rattlesnake), the Only Poisonous Snake Indigenous to Michigan. (Courtesy of L. M. Klauber, Reference 2).

MASSASAUGA BITES IN MICHIGAN

BY HENRY M. PARRISH, M.D., DR.P.H.

Massasaugas are small rattlesnakes of the genus Sistrurus. They are the only poisonous snake indigenous to Michigan.[1,2] Poisonous snakebites are not common in the East North Central Region of the United States, but they occur more frequently than many people suppose.

Michigan has the second highest annual snakebite rate of the states in this region. The annual snakebite rates per 100,000 population are: Indiana (0.97); Michigan (0.74); Ohio (0.46); Wisconsin (0.38) and Illinois (0.35).

Deaths from poisonous snakebites are rare in Michigan—there were no deaths during the ten-year period, 1950-1959.[3]

Almost nothing has been published about poisonous snakebites in Michigan. The purposes of this study are: (1) to describe the pattern of poisonous snakebites in Michigan; (2) to relate some medical findings associated with these bites; and (3) to review briefly current concepts of snakebite treatment.

MASSASAUGAS

According to Conant,[1] the eastern massasauga *(Sistrurus catenatus catenatus)* is the only poisonous snake indigenous to Michigan. Klauber[2] stated that this snake is generally distributed in Lower Michigan, but has not been reported in Upper Michigan. The massasauga also is called the "swamp rattler" or the "black snapper." It is a relatively small snake, 12 to 30 inches in length, with dark blotches on the back. Some specimens are almost entirely black. In general, they prefer a swampy environment. See Figure 1 for a photograph of a massasauga.

Massasaugas are pit vipers. Other pit vipers not indigenous to Michigan are the larger rattlesnakes *(Crotalus sp.)*, copperheads and cottonmouth moccasins. Pit vipers are so named because of a characteristic pit which is located between the eye and nostril on each side of the body. Pit vipers also are identified by elliptical pupils and by two well-developed fangs which protrude from the maxillae when the snake's mouth is opened. Rattlesnakes have rattles which are attached to their tails. Harmless snakes do not have facial pits, they have round rather than elliptical pupils, and while they have teeth, they lack fangs.

Oftentimes people will chop off the head of a snake which has bitten someone and bring the



SCIENTIFIC PAPERS

From the Department of Community Health and Medical Practice School of Medicine, University of Missouri, Columbia, Missouri.

This investigation was supported in part by Public Health Service Research Grant GM 11268-02 from the Division of General Medical Sciences, Public Health Service.

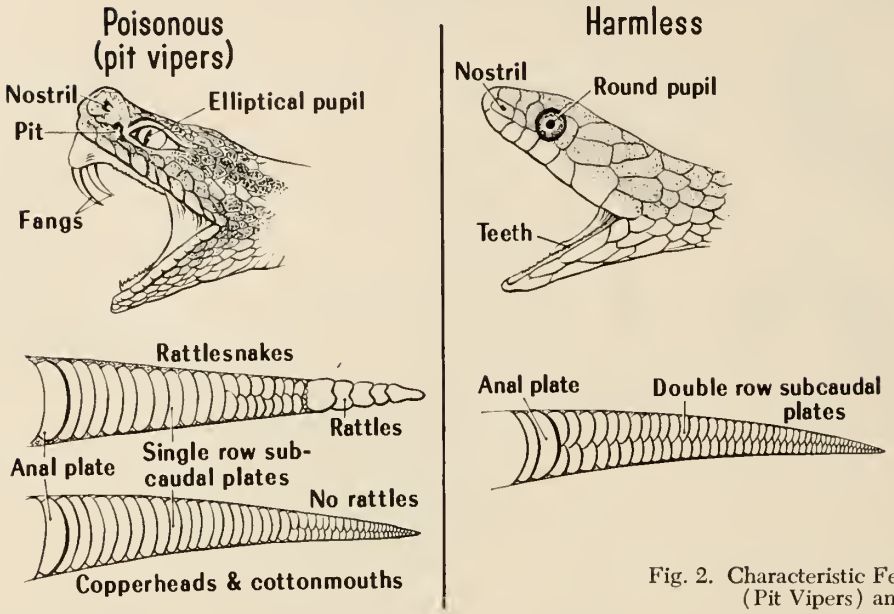


Fig. 2. Characteristic Features of Poisonous (Pit Vipers) and Harmless Snakes.

snake's body in for identification. Pit vipers can be identified by turning the snake's belly upwards and noting a single row of subcaudal plates just below the anal plate. Harmless snakes have a double row of subcaudal plates.

Figure 2 depicts the characteristic features of pit vipers and harmless snakes.

METHODS OF STUDY

A questionnaire and letter explaining the purpose of this study were mailed to a "selected" group of Michigan hospitals listed in Hospitals (Journal of the American Hospital Association) Guide Issue. The hospitals selected for this study were general hospitals, children's hospitals and college infirmaries. Army, Navy, Coast Guard, Public Health Service, Air Force and Veterans Administration hospitals also were sent questionnaires. Maternity, tuberculosis and mental hospitals were omitted as they would not be expected to treat snakebite victims. A total of 191 Michigan hospitals comprise the study group. Each hospital was requested to report all in-patients admitted to the hospital for snakebite treatment during 1958 and 1959.

Most hospitals do not code and tabulate the diagnoses of emergency room and out-patient clinic visits. Since some snakebite victims are not admitted to the hospital as in-patients, it seemed essential to ask a sample of practicing physicians how many snakebite victims they treated on both an out-patient (office, home, emergency room, et cetera) and on an in-patient basis.

Previous surveys[4,5] have shown that most people with venomous snakebites are treated by general practitioners, surgeons, internists, pediatricians, and orthopedic surgeons. Therefore, a random sample of one-third of all the Michigan physicians in these categories of practice who were listed in the AMA American Medical Directory were sent questionnaires.

Death certificates for fatal snakebite cases were obtained from the Michigan Department of Health.

RESULTS

This report is based on questionnaires returned by 190 (99 per cent) of 191 Michigan hospitals. It is supplemented by questionnaires returned by 981 (77 per cent) of 1,272 practicing physicians in the State. The Michigan Department of Health indicated that there were no snakebite deaths during 1958 and 1959.

Incidence.—Michigan hospitals reported a total of 29 in-patients treated for poisonous snakebites during 1958 and 1959. There were 14 cases in 1958 and 15 cases in 1959—an average of 14.5 cases per year. *All of the analyses in this paper, excluding the estimate of incidence, were based on the 29 detailed case reports received from hospitals.*

Physicians' reports, when adjusted to account for all Michigan physicians in the practice categories mentioned, indicated that approximately 26 in-patients and 32 out-patients were treated for snakebite accidents each year. The difference between the estimate of 26 in-patients treated by physicians and the average of 14.5 in-patients reported by hospitals can be explained, in part, by the following facts: (1) one large hospital did not participate in the study; (2) there was evidence of under reporting snakebite in-patients from five hospitals which participated in the study; and (3) physicians indicated that some in-patients were treated in

small clinics and hospitals not listed in Hospitals Guide Issue.

Taking all of these various reports into consideration, I estimate that approximately 58 (26 in-patients and 32 out-patients) people are treated annually for poisonous snakebites in Michigan. This provides an incidence of 0.74 bites per 100,000 population per year.

Geopathology.—The geographical distribution of snakebites reported in Michigan during 1958 and 1959 may be seen in Figure 3. The lightly shaded counties are those from which hospitals reported in-patients treated for snakebites. An appropriate symbol is used to mark each hospitalized patient who was bitten by a specific kind of snake. The darker shaded counties are those counties from which physicians reported snakebite cases, but from which no cases were reported by hospitals.

Of 29 people hospitalized for snakebite treatment for whom detailed records were available, 19 (66 per cent) were bitten by rattlesnakes and 10 (34 per cent) by unidentified poisonous snakes. Two professional snake handlers were bitten by western diamondback rattlesnakes *(Crotalus atrox)* while handling snakes during sideshows in Cheboygan. The other 17 rattlesnake bites presumably were inflicted by massasaugas *(Sistrurus catenatus catenatus)*.

Figure 3 shows that no poisonous snakebites were reported from Upper Michigan. The majority of bites were reported from the southern one-half of Lower Michigan. If one excludes the two bites by non-native, western diamondback rattlesnakes in Cheboygan, all of the rattlesnake bites were in the southern one-half of Lower Michigan. Likewise, with one exception, all of the bites by unidentified poisonous snakes were in the southern part of Lower Michigan. Most likely these bites also were inflicted by massasaugas. This geographical distribution of bites is consistent with the ecological range of massasaugas in Michigan described by Conant[1] and Klauber.[2]

Temporal Relationships.—The monthly distribution of snakebite accidents is shown in Table I. Snakebites were infrequent during the colder months of the year—November through April. In general, snakes are usually inactive and/or hibernating during the colder months.

All of the snakebites in Michigan happened from May through October. August was the peak month for bites. This striking seasonal distribution of bites coincides with the time that snakes are most abundant and active and with the time that people have greater exposure due to out-of-doors occupations and recreation. Similar "seasonal epidemics" of venomous snakebites have been observed in New England, and North Carolina.[4,5]

The time of day when most snakebite accidents happened was the six-hour period from 3:00-8:59 P.M. when 16 (55 per cent) people were bitten. The number of bites by three-hour periods of time were: 6:00-8:59 A.M., 2 bites; 9:00-11:59 A.M., 4 bites; 12:00 noon-2:59 P.M., 3 bites; 3:00-5:59 P.M., 10 bites; 6:00-8:59 P.M., 6 bites. There were no

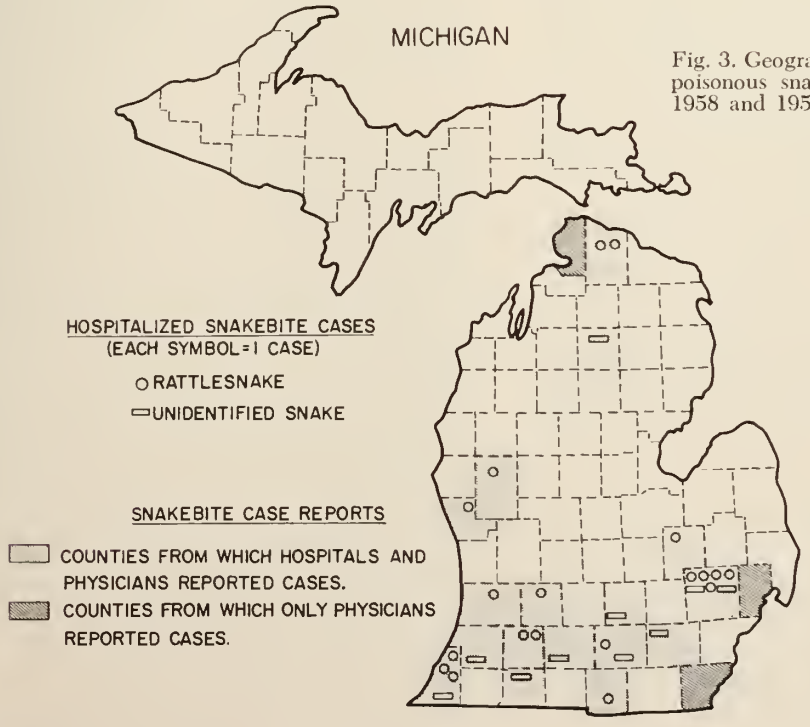


Fig. 3. Geographical distribution of poisonous snakebites in Michigan, 1958 and 1959.

Tables of Information About Snakebites:

TABLE I. SEASONAL DISTRIBUTION OF POISONOUS SNAKEBITES IN MICHIGAN 1958 and 1959

Month	No. Bites	Month	No. Bites
January	0	July	6
February	0	August	8
March	0	September	5
April	0	October	2
May	2	November	0
June	6	December	0

TABLE II. AGE DISTRIBUTION OF HOSPITALIZED SNAKEBITE VICTIMS IN MICHIGAN 1958 and 1959

Age Group (years)	Population at Risk*	No. Bites	Rate per 100,000**
0-9	1,848,246	9	0.49
10-19	1,307,678	10	0.76
20-29	920,921	2	0.22
30-39	1,094,460	3	0.27
40-49	969,972	3	0.31
50-59	750,886	2	0.27
60-69	543,763	0	0.00
70 or more	387,268	0	0.00

*Based on the 1960 Census of the Population of Michigan.
**These rates are only on hospitalized patients for whom information was available.

TABLE III. ANATOMICAL SITES OF BITES INFLICTED BY POISONOUS SNAKES IN MICHIGAN 1958 and 1959

Anatomical Site of Bite	Side of Body Right	Left	Total No. of Bites
Head, face & neck	0	0	0
Trunk, front	0	0	0
Trunk, back	0	0	0
Upper arm	0	0	0
Forearm	0	1	1
Hand	2	3	5
Fingers	8	4	12
Upper leg	0	1	1
Lower leg & ankle	4	1	5
Foot	3	2	5
Toes	0	0	0

bites between 9:00 P.M. and 5:59 A.M. For four cases the time of the bite was not recorded.

Bite Victims.—There were 16 white males, 12 white females, one non-white male and no non-white females admitted to Michigan hospitals for snakebite treatment during 1958 and 1959. The non-white male was a Negro. Using the 1960 census for the population of Michigan the bite rates per 100,000 population were: 0.45 for white males, 0.28 for non-white males, 0.34 for white females and 0.00 for non-white females. Thus, males had higher snakebite rates than females and whites had higher rates than non-whites.

The age distribution of Michigan bite victims is shown in Table II. The largest number of bites happened to children and youths 10-19 years of age (10 bites) and those 0-9 years of age (9 bites). Indeed 66 per cent of all snakebites were inflicted on children and young adults less than 20 years of age. Age-specific bite rates are much more meaningful since they take into account the population at risk in a particular age group. The highest biannual bite rates per 100,000 population were: 10-19 years of age (0.76) and 0-9 years of age (0.49). The lowest bite rates were found among people 60 or more years of age.

An analysis of the occupations of the patients showed that 15 were children and two each were housewives, professional snake handlers, managers, clerical workers, farm laborers and laborers other than farm laborers. One victim was a craftsman and the occupation was not coded for one patient.

Site and Severity.—The anatomical sites on human beings where poisonous snakes inflicted their bites are shown in Table III. All of the bites were inflicted on the extremities—62 per cent on the upper extremities and 38 per cent on the lower extremities. The fingers and hands were the parts most often bitten on the upper extremities. The feet and lower legs, including the ankles, were the parts most frequently bitten on the lower extremities.

A modification of the clinical classification of pit viper venenation by Wood, Hoback and Green[6] was used to determine the severity of bites. Bites were classified as follows:

Grade O—*No venenation.* Fang or tooth marks, minimal pain, less than 1 inch of surrounding edema & erythema. No systemic involvement.

Grade I—*Minimal venenation.* Fang or tooth marks, severe pain, 1-5 inches of surrounding edema & erythema in first 12 hours after bite. No systemic involvement usually present.

Grade II—*Moderate venenation.* Fang or tooth marks, severe pain, 6-12 inches of surrounding edema & erythema in first 12 hours after bite, systemic involvement may be present—nausea, vomiting, giddiness, shock or neurotoxic symptoms.

Grade III—*Severe venenation.* Fang or tooth marks, severe pain, more than 12 inches of surrounding edema & erythema in first 12 hours after bite, systemic involvement usually present as in Grade II.

The severity of venenation (venom poisoning) was classified as follows for 20 hospitalized cases: 10 (50 per cent) were Grade O; five (25 per cent) were Grade I; two (10 per cent) were Grade II; and three (15 per cent) were Grade III. Not included in this analysis of severity were two men bitten by western diamondback rattlesnakes which

resulted in Grade III-severe venenations, and seven cases in which the severity was not stated.

There were no deaths among the 29 hospitalized cases in this series. Furthermore, there were no snakebite deaths in Michigan from 1950 through 1959.[3] The case-fatality rate for massasauga bites in Michigan is estimated to be less than one-tenth of one per cent.

Most deaths from snakebites in the United States result from bites by the larger rattlesnakes *(Crotalus sp.)*. Bites by the smaller rattlesnakes *(Sistrurus sp.)* are not nearly so lethal, especially if they are treated adequately. The low case-fatality rate from snakebites in Michigan may be attributed to: (1) the fact that massasaugas are small rattlesnakes whose bites are not so lethal; (2) the prompt availability of medical care; and (3) the effectiveness of current snakebite treatment.

TREATMENT

The current treatment of North American pit viper (rattlesnake, cottonmouth, moccasin and copperhead) bites includes both minor surgery and medical forms of treatment. A constricting band (tourniquet) should be applied lightly to the involved extremity several inches proximal to the bite. The constricting band should be applied only tight enough to occlude the superficial venous and lymphatic flow. *It should not occlude the arterial circulation* and it should be released every 10-15 minutes for a minute or two. As edema resulting from venom poisoning spreads, the constricting band should be advanced to keep just ahead of the swelling. The purpose of the constricting band is to impede the spread of venom until incision and suction can be used to remove the venom mechanically and/or until antivenin can be administered to neutralize the venom.

Incision and suction (I.S.) is effective in removing venom from experimental animals up to about 120 minutes after the venom is injected. The sooner it is used, the larger the amount of venom that can be removed. Suction should be used for about one hour. We have found the suction cups supplied in the Cutter and the Becton-Dickinson snakebite first-aid kits effective for removing pit viper venom.

Incisions, one-quarter inch long and one-eighth to one-quarter inch deep, are made into the subcutaneous tissues over the fang punctures. A few (3-5) additional incisions may be made in the surrounding edematous tissues. A large number of incisions is not needed. Immobilization aids in limiting the spread of venom. However, if one must decide between immobilization or seeking prompt medical treatment, the latter should be sought.

The "3 A's" (antivenin, antibiotics, and tetanus antitoxin and/or toxoid) are recommended, in addition to I.S., in treating all serious pit viper bites. Antivenin Crotalidae Polyvalent (Wyeth) is effective in neutralizing the venoms of all North American pit vipers. It is not protective against coral snake venom. Since antivenin is manufactured from horse serum, the patient should receive a skin test before antivenin is given.

For Grade I venenations, antivenin may be administered in the deltoid or gluteus muscles. In Grade II and Grade III venenations, antivenin diluted in 1000 cc. of normal saline may be given intravenously.[7] Studies with radioisotopes have shown that antivenin accumulates at the site of the bite more rapidly after intravenous administration than after intramuscular administration.[8] Injection of antivenin into the local bite area is not a particularly effective way to administer antivenin. We have found the following amounts of antivenin useful in treating the various Grades of venenation: Grade O (no venenation) requires no antivenin; Grade I (minimal venenation) may require 10 cc. (one ampoule) of antivenin; Grade II (moderate venenation) requires 30-40 cc. of antivenin; and Grade III (severe venenation) requires 50 cc. or more of antivenin.

Since snakes' mouths and venoms may harbor pathogenic organisms, antibiotics and tetanus antitoxin and/or toxoid should be given prophylactically. Gram negative organisms predominate, hence a broad spectrum antibiotic is indicated. Penicillin used by itself is not adequate treatment.

Cortisone and ACTH do not affect the survival rate of animals poisoned with pit viper venom. They probably should not be used during the first few days after venenation, although they may be beneficial later in treating serum sickness resulting from antivenin therapy. Antihistamines are contraindicated as they shorten the survival time of animals poisoned with pit viper venoms. Shock resulting from venom poisoning should be treated with infusions of blood, plasma, saline solution and vasopressor drugs. Meperidine hydrochloride and other analgesics may be given to relieve pain. Recently there have been reports of excessive tissue necrosis and amputations associated with cold therapy such as packing an extremity in ice or using ethyl chloride.[8] In my opinion, cold therapy should not be used in treating pit viper bites.

SUMMARY

Michigan has the second highest annual incidence of poisonous snakebites of the states in the East North Central Region of the United States. An estimated 58 (26 in-patients and 32 out-patients) people were bitten by snakes annually—an incidence of 0.74 bites per 100,000 people. How-

ever, the estimated case-fatality rate was less than one-tenth of one per cent.

Of 29 in-patients reported in detail by Michigan hospitals during 1958 and 1959, 19 (66 per cent) were bitten by rattlesnakes and 10 (34 per cent) by unidentified poisonous snakes. "Seasonal epidemics" of snakebites occurred with all of the bites inflicted from May through October. August was the peak month for bites. All of the bites happened in Lower Michigan, none in Upper Michigan.

Males had higher bite rates than females, and whites had higher rates than non-whites. Sixty-six per cent of the cases were among children and young adults less than 20 years of age. All of the bites were on the extremities—62 per cent on the upper extremities and 38 per cent on the lower extremities. Current snakebite treatment is discussed.

ACKNOWLEDGMENT

The author cites with gratitude the technical assistance of the following persons: Judi Pummill, Genevieve Calescibetta, and Linda Hinson.

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Physician Employment in the 1960's

The U. S. Labor Department in its Occupational Outlook Report gives the following information to high school youngsters about M.D. job opportunities:

"A steady increase in demand for physicians' services is in prospect in both the near future and the long run. The need for medical services will be increased by the anticipated growth and change in the age composition of the population, the rising health consciousness of the public, and the trend toward higher standards of medical care.

"Continued Federal Government provision of medical care for veterans and for members of the Armed Forces and their families, and the continuing growth in the fields of public health, rehabilitation, industrial medicine, and mental health will also tend to bring about a need for more doctors. In addition, expanded medical research activities will require more trained investigators; medical schools will have openings for additional faculty members; and the growing number of hospital training programs will require more interns and resident physicians.

"The rise in demand for physicians' services will be limited to some extent by advances in medical science and more efficient use of medical personnel. The introduction of new drugs and medical techniques, the more extensive use of assistants trained in other health occupations and the increasing proportion of patients treated in hospitals rather than at home will probably enable individual physicians to care for more patients.

"Improved roads and transportation facilities as well as the movement of people to urban areas will continue to decrease the time needed to make house calls. Nevertheless, population expansion and the general rise in use of medical services are expected to outweigh any lessening in demand for physicians arising from other developments. For all these reasons, the long-run outlook is very bright for young people who have proper qualifications and are able to gain admittance to medical school.

"Women physicians, who represent about 6 per cent of the profession, will continue to find good opportunities as general practitioners and as specialists. In 1960, about 6 per cent of all medical school students were women."

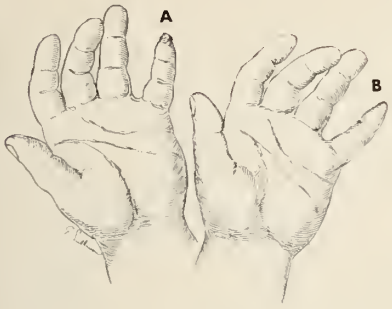


Fig. 1. The loss of small areas of finger tip skin in young children will heal rapidly by secondary intention without the need for operative treatment.

The Common Finger Tip Injury

BY
WILLIAM C. GRABB, M.D.
REED O. DINGMAN, M.D., FACS

Trauma to the finger tips is quite common. These injuries may cause the loss of skin as well as tactile pad, distal phalangeal bone, and fingernail. Repair of the finger tip following the loss of tissue should be individualized in order to provide a nontender finger with the maximum sensory function, length, and range of motion.

Any of the following techniques may be employed depending upon the age of the patient, the finger involved, and the extent of tissue loss.

ALLOW WOUNDS TO HEAL BY SECONDARY INTENTION

Young children, particularly those under four years of age, who have a loss of superficial finger tip tissue less than 1 cm. in diameter usually require no treatment other than to treat the wound by dressing changes (Fig. 1). These wounds heal rapidly by epithelization and contraction of the defect over the period of a few weeks.

This exception to the usual rule of primary closure of wounds applies only to young children. In older children and adults, more elaborate treatment is required.

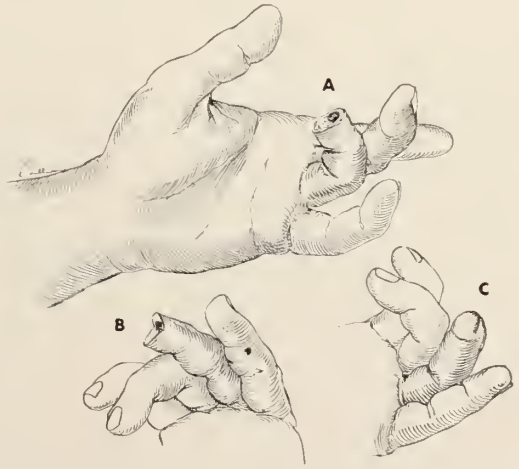
PRIMARY CLOSURE

Finger tip injuries which result in the exposure of bone can be treated by primary closure (Fig. 2). This technique is especially applicable when there is a dorsal or volar flap of viable skin available. It can also be employed for closure of the severed middle, ring, or little finger tip where maintenance of length is not so important. This is particularly true in the laborer's hand.

A practical technique for primary closure of the guillotine finger tip amputation is to shorten the distal phalangeal bone with a rongeur, excise a "V"-shaped piece of skin from the medial and lateral aspect of the finger tip, and then suture the resulting skin flaps (Fig. 2). An effort should be made to design the flaps so that the suture line will be on the dorsum of the finger in order to avoid a scar on the tactile surface.

If the nail has been almost completely destroyed it is best to curette away the remaining nail matrix

Fig. 2. Primary closure is especially applicable for treatment of the amputated little, ring or middle finger tip where the maintenance of finger length is not so important. It is often necessary to shorten the distal phalangeal bone and excise a "V"-shaped portion of soft tissue and skin in order to obtain closure.



From the Department of Surgery, School of Medicine, University of Michigan and the Department of Plastic Surgery, St. Joseph Mercy Hospital, Ann Arbor, Michigan.

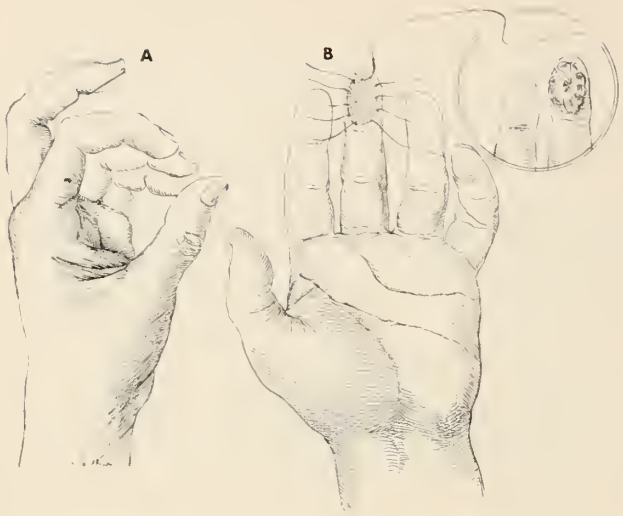


Fig. 3. A skin graft can be used for wound closure when skin and a superficial portion of tactile pad are lost. After the graft has been sutured in place, the sutures can be left long and tied over a cotton ball to hold the graft in contact with the wound.

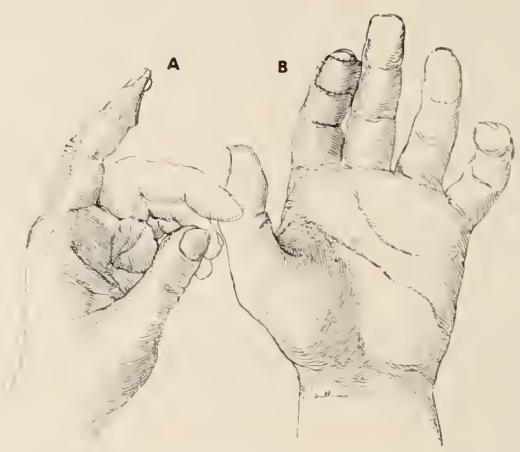


Fig. 4. A cross finger flap will provide wound closure when distal phalangeal bone is exposed. The flap donor site on the dorsum of the adjacent fingers can be closed with a split thickness skin graft.

to prevent the growth of troublesome irregular pieces of nail. It should be remembered when curetting, that the martix of the nail extends quite proximally, beginning at the insertion of the conjoined tendon of the extensor mechanism.

SKIN GRAFTS

The slicing finger tip injury in which skin and a superficial portion of tactile pad are lost can be treated by closure with a split thickness skin graft (Fig. 3). The graft will gradually contract during healing with a decrease in size of the finger tip defect by as much as 50 per cent. Nerve endings can be expected to grow into the graft so as to provide satisfactory sensation of the finger tip.

Skin grafts provide an unsatisfactory coverage for exposed bone, even though it is just a cross section of the bone resulting from guillotine amputation of the finger tip. Grafts which become adherent to bone usually result in a tender disabling scar.

These skin grafts can usually be applied in the emergency room under local anesthesia. Obviously devitalized tissue can be debrided and hemostasis can be obtained with a fine tipped electrocautery. The split thickness skin graft is usually obtained with a razor blade from the deltoid region in males or the buttock in females. The graft can be sutured in place and the suture ends used to tie over a cotton ball to hold the graft in contact with the wound. This dressing can be removed in five to seven days.

SKIN FLAPS

Injuries to the finger tips which result in a loss of skin and tactile pad so that bone is exposed can be repaired with a skin flap (Fig. 4) or by shortening the distal phalangeal bone and closing the wound by primary suture. A skin flap is indicated especially when the index finger or thumb are involved, as it is important to retain all possible length of these fingers. The thumb, index, and middle finger tips are the ones injured most commonly.

The cross finger flap is preferred to the palmar, abdominal, or chest wall flap. Use of the palmar flap results in an increased incidence of finger joint stiffness, while the abdominal and chest wall flaps are too bulky and provide poor sensory function.

Cross finger flaps are elevated usually from the dorsum of the middle phalanx of the adjacent finger. The flaps can extend from the midlateral line on one side of the finger to the midlateral line



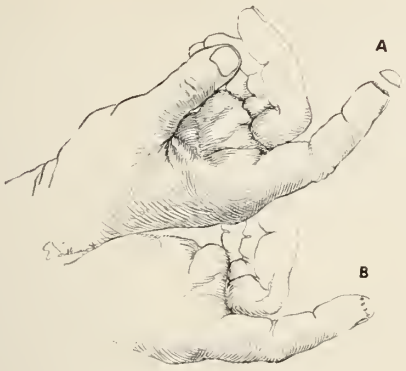


Fig. 5. Cleanly severed finger tips may survive if they are sutured back in place within three or four hours.

on the other side, avoiding the joint creases. A thin layer of areolar tissue is left on the extensor tendon so that a split thickness skin graft can be sutured over the defect and held in place with a tie-over dressing. It is unnecessary to take special precautions to keep the fingers from pulling apart. The base of the flap can be divided safely in about two weeks.

Multiple finger tip injuries with loss of skin and tactile pad can be repaired with multiple cross finger flaps or a cross arm flap. The cross arm flap utilizes the thin hairless skin of the upper forearm for coverage, which is preferable to the thick flaps obtained from the abdominal and chest walls.

RESUTURE OF SEVERED FINGER TIP

The resuture of cleanly severed finger tips should be mentioned although the rate of success has been discouraging (Fig. 5). Obviously the smaller, less contused portions of skin and tactile pad have the best chance of surviving. It is important to resuture the severed finger tip within three or four hours of the time of injury. If the finger tip is to become viable there will be a return of color in two or three days.

SUMMARY

Useful methods for the repair of common finger tip injuries with loss of tissue have been presented. Treatment must be individualized in order to obtain a healed finger tip with the maximum sensory function, length, and range of motion and with minimal tenderness, joint stiffness, and intolerance to cold.

COMING IN SEPTEMBER

WATCH FOR these and other timely and informative articles scheduled to appear in coming issues.

Overweight Children

A. F. Robertson, M.D., and G. H. Lowrey, M.D. A review of the problems of obesity in children, based upon the records of 100 overweight children, none of whom had a specific endocrinological disorder.

Adrenalectomy for Ascites

C. P. Petermann, M.D. A case report of a new approach to the treatment of intractable ascites.

A Clinical Evaluation of Polythiazide

J. F. Sanders, M.D. A 15-month study of the use of polythiazide in 135 aged domiciliary patients.

A placebo effect is discoverable in medication independent of the pharmacological action thereof. The placebo effect is the psychosomatic resultant of psychological processes which have become unconsciously attached to therapeutic endeavors. Symbolizing as it does to the patient the gratification of infantile needs, the placebo can serve to relieve functional components of discomfort and disability. Placebo should be acknowledged as a potent force of our therapeutic armamentarium.

The Therapeutic Use Of Placebo

BY GORDON R. FORRER, M.D.

Amid the swirly smoke in a flame-lit hut a witch doctor shakes a secretly compounded powder on a supine "patient." Wildly chanting his primitive litany, he watches the "patient" recover and rise to his feet. He has performed the seemingly miraculous. A man thought dead has become once more alive. Another "cure" has been added to a long list of other successes the sorcerer has to his credit.

A little boy comes screaming to his mother. He has just fallen and scratched his knee. The mother gathers him up and crooning her sympathy, kisses the injury. The child first stops crying, then smiles and wiggles to be let down to return to his play. His mother's caress has cured his hurt and if you ask him, he will tell you that it was indeed her kiss —the touch of her lips—that took away the pain.

A nurse on night duty sees the flashing of a night light and goes to see how she can be of help. A patient cannot sleep. An order for a sleeping capsule has been left and the nurse now fills the doctor's order. Even before she has left the patient's room she observes that he is already asleep! She is so used to this kind of occurrence that she doesn't pause to consider the curious fact that the patient reacted to the drug *even before its pharmacological effects could have begun.*

At first glance the three episodes are independent of each other in time and space and have nothing whatsoever in common. The witch doctor's sorcery is thousands of miles and as many years away from the sophisticated pharmaceutical industry. And neither episode seems to have the remotest relationship to a mother's concern for her son's skinned knee! But we discover that there is, indeed, a relationship which joins together these otherwise disparate occurrences. For observe that in each instance a therapeutic effect has been brought about by means which are not at all self evident and which, in fact, seem to have no real relationship to these therapeutic results.

At first, all we observe is that "something has been done" allowing for the fact that a descriptively different act was performed in each case.

And since in each instance, "what was done" could not have produced the observed effects by itself, we must assume that a goodly measure of the effect was unrelated to "what was done." In other words, the dramatic effects which were observed had little to do with what seemingly was done to produce them.

Every medication, every surgical and medical procedure, has besides the mechanical and pharmacological effects on those to whom they are administered, influences which are entirely psychological. A great many factors enter into the extent, quality, and direction of these psychological events. We are accustomed to refer to them as placebo effects, and as every physician knows, these effects can be "for bad" as much, but not as often, as "for good." Just how many "side effects" are negative placebo reactions rather than the consequences of undesired pharmacological activity will probably never be known for man has as great a capacity to avoid seeking solutions to curiosity arousing observations as to pursue them. Modern day emphasis on pharmacological potency tends to obscure the fact that every drug has unmeasureable, but highly significant placebo components. Frequently patients react to drugs as "they are expected to" by medical people and in no field is this more evident than in psychiatry.

Looking back through hundreds of years, or even less, it is easy to see that even though it was unrecognized at the time, most of the efficacy of medical practices was in fact ascribable to the placebo effect. We can make such a claim with

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justification, for drugs of proven pharmacological inactivity were, according to reports, as effective in certain illnesses as their modern-day pharmacologically active counterparts.

Now patients and doctors of these ancient times have something in common with patients and doctors of these modern ones. Most of us adhere unthinkingly to the assumption that medical practices are effective *solely* because of their physical or pharmacological elements. The placebo effect is quietly ignored despite its ubiquitous importance. In fact, because of the demonstrable pharmacological activity of modern drugs, we mistakenly and understandably attribute *all* of their therapeutic efficacy to this particular fact. We casually ignore, indeed, we studiously avoid any real attentiveness to the fact that the very administration of a drug produces psychological as well as physiological effects.

Take the many compounds available to induce sleep. There are many people who would stoutly maintain that these medicines produce sleep only because of their pharmacological potency; a property undoubtedly possessed by them.

The idea is attractively simple but hardly suffices for the physician who daily sees all sorts of "odd" occurrences such as the one I related at the beginning of this article. Even a student nurse with the smallest of clinical experience knows that the medicinal potency of pharmacological compounds *exceeds* the sum of their separate parts. For what nurse has not observed that a warm glass of milk, gently and with kindness given, is as good a sleeping capsule in most cases and certainly better than a routine "h.s." pill in many? And who has not, with some astonishment and unspoken surprise, observed how a "pill" accomplished an effect much more rapidly than it was supposed to? And experienced nurses have long been familiar with the pain-relieving properties of a "sterile hypo." But most of us are too busy to take time to ponder on these seemingly insignificant occurrences. Besides, they arise with such frequency and regularity that even if they do at first strike us as strange, they soon come to be accepted without evoking any further comment or curiosity, and especially if we should ask someone about them, no one seems able to explain them to our satisfaction.

We observe that medicinals have an effect—regardless of the composition of the substances contained within them. And further, we know that the placebo effect is not always favorable in terms of therapeutic response. It is my conviction, as I have suggested earlier, that many of the "side effects" ascribed to various medications are, in fact, what can be called "negative placebo responses." It is not at all rare, for example, to observe adverse reactions following the administration of drugs—reactions which have nothing whatsoever to do with the pharmacological properties of the drug, but very much to do with the psychological factors which neither patient nor doctor nor nurse are very much aware.

One of the most amazing events in medical practice is to observe a "side effect" from nothing more potent than a sterile hypo, or even from nothing more pharmacological than a venipuncture.

The placebo responses, both the negative and positive, are so universal, so close to us day by day in our work, that we easily overlook them. Indeed, we remark upon the placebo response only when its manifestations are so remarkable that we cannot well escape the fact of it. It is probable that without the placebo effect to help us, we should be able to relieve the suffering of our patients far less frequently and far less efficaciously than we do.

It seems to me that the nurse's function most valued by patients are just those soothing ministrations which evoke positive placebo responses.

Now it is no secret that some painful disabilities have no organic basis, but are entirely functional in nature, just as it is generally unappreciated that *every* illness has a psychological or functional component. If a man, through accident, loses the tip of the little finger of his left hand, the misfortune is generally of no particular psychological consequence. There is a psychic response to such injury, of course, but because generally it is of small significance, it is by custom assumed to be absent. But let the injured man, deprived of the same part of the fifth finger of his left hand be a concert violinist and the loss is no longer a minor inconvenience. What may be trivial for one man can be catastrophic for another.

The example I offer is an extreme one, purposefully chosen to support the concept that all illnesses, composed as they are of varying proportions of organic and psychological factors, are "Psychosomatic." We are, of course, long accustomed to acknowledge these "psychosomatic" elements despite the fact they cannot be easily or readily delineated. We next consider the question of the means by which the placebo components of medical procedures come to exercise "miraculous" effects.

We may take it that the greater the proportion of the psychological component, the more impressive the placebo effect of medication will be. There will generally be little placebo effect from medication where the illness is largely physical. On the other hand, "medical miracles," even "authenticated" ones are not rare where the proportion of psychic factors to physical ones is great. And it is by reason of this varying and uncertain proportion that we are limited in the benefit we can confer upon suffering mankind through the exploitation of the placebo effect.

There is no simple, easily learned way in which

the psychic component of illness may be separated from the organic, and no way at all in which these two intertwined and variable factors may be measured. The employment of the placebo in any rational way is still beyond our skill, though it may yet yield to our control at some future time. Perhaps some medical genius will devise a "psychosomatic index" which will provide a precise measure of the ratio of psychic to physical in sick people. It would be most helpful in our daily rounds of caring for the ill.

It is of some interest in this regard that in Asia, especially in China, the ancient art of acupuncture is practiced to this day and the same is true of parts of Russia and Japan. Acupuncture is a technique of treating disease in which needles are inserted in various pre-determined parts of the body. The body has been "mapped" so that each land mark represents a certain organ or infirmity. Needles inserted are supposed to have therapeutic effect on the part, organ, or disease "controlled" by that particular spot. These needles remain in place for pre-determined but variable periods of time according to the very exacting requirements of the art. And although nothing more than this ritual is performed, a great deal of success has been claimed for this method of "treatment" by its proponents.

These results are not fakery or charlatanism. These results are confirmatory evidence of the universal magic of the placebo exercising its effect upon the physical through the psyche. Even closer at home we are aware of the great claims made for the practice of chiropractic. This is the system of treating human ills based upon the theory—indeed, the delusion—that misaligned vertebrae and the subsequent pressure on nerve roots is responsible for all human ills. One need only observe the flourishing state of this cult to be convinced of the magical efficacy of such manipulations. Despite every rational objection, the disconcerting fact remains that a not insignificant number of sufferers are relieved by methods but one step removed from the African sorcerer's medicine hut.

We can see that the placebo is a very real force and that men from time immemorial have attempted to exploit its influences for the alleviation of man's suffering. The origin of the placebo effect is disarmingly simple. In the earliest weeks of our lives all of us had approximately equivalent experiences. We existed in a blissful, unboundaried haze which was generally pleasant.

Any suffering we had, any hunger we felt, was quickly relieved by our loving mothers and it is to that unforgettable experience—so elusive and unspeakable—that the placebo response can be traced. And the analysis is made the more difficult because we have no verbal memories of this early age but must depend upon what we observe in infants and what we can reconstruct from the wordless feelings people experience and tell us about. It will be recalled that at first, the newborn infant is but a bundle of feelings and is incapable of conceptualization and of verbalization. Indeed, it is generally well over a year before he comes to use words in more than the most rudimentary sense and a considerably longer period than that before his powers of reasoning manifest themselves. That an infant experiences discomfort and pain from time to time, there can be no doubt. And when he does experience such discomforts, the appropriate "treatment" of that is plainly apparent to his mother. Hunger is necessarily a daily experience with every infant. For until he feels hunger and cries, his mother does not know of his need. And it is her feeding of him that relieves his pain and discomfort. Thus, from the earliest time of life one begins to associate the taking in of something with the relief of discomfort. It has been as a consequence of his effort to relieve discomfort that man has employed every known substance, at one time or another in his history, as "medicine."

Now whether the medicine is taken by mouth, injected, soothed on, or however it enters or is placed upon the body, it takes on a symbolic significance for the adult. The "medicine" of the adult has been equated in the unconscious mind with an earlier "medicine"—the milk which relieved the discomfort of the hungry infant. Nor must the "placebo effect" be limited to just those substances or objects which enter the body.

Sometimes just the touching of the body by the hands of another is taken as a symbolic re-enactment of the earliest "laying on of hands"—the loving hands of the mother who holds and fondles her infant.

It is no accident that nurses are called "nurses." It is absolutely certain that the profession of nursing will forever remain in the hands of women for, though we remember it not, it is undeniable that it was through the loving touch of a woman's hand that we first experienced relief from discomfort. Indeed, the very presence of a nurse has a kind of placebo effect upon suffering patients. And more than one nurse can attest to the fact that she has been called to a patient's room "needlessly." She was called for no reason other than the "placebo effect" which her very presence conferred upon the anxious and very uncomfortable sufferer. And is there a nurse living who has not, at one time or another, been "mistakenly" called "mother" instead of "nurse"?

SUMMARY

The placebo effect is a universal one, utilized in various ways and means throughout the ages for the relief of mankind's discomforts. Its origins are to be found in the earliest relationship between the infant and the mother who nurses him.

Due to increased patient age and broadening of indications for resectability and operability in the cancer or jaundiced patient, the occurrence of wound dehiscence and evisceration is increasing. As no rapid technique for definitive closure without benefit of general or spinal anesthesia is described, we have presented a procedure for rapid closure of wound disruption in the poor risk patient. The method entails local anesthetic infiltration of the abdominal wall down to the peritoneum after adequate preoperative medication and preparation of the area. Large silk, plastic or stainless steel sutures are passed through the abdominal wall, onto a malleable retractor, which protects the viscera beneath. A similar retractor, protects the viscera on the opposite side as the needle is passed from peritoneum to skin. The sutures which are placed at 1.5 cm. intervals are tied over gauzes or ABD Pads and removed in sixteen to twenty-one days.

Rapid Safe Closure of Wound Disruption In the Poor Risk Patient

BY GEORGE C. HILL, M.D.

SECONDARY closure of dehiscence and evisceration can be a very important feature in the total care of the patient. On any surgical service, the indications for either prophylactic retention sutures or for emergency wound separation closures continue to increase. This increase in no way reflects on the efficacy of current surgical technique but rather is an index of the increase in the overall age range of the patients, as well as broadening of the operability and resectability indications in the cancer patient.[1]

Despite the apparent demand for this procedure little information regarding a definitive rapid technique can be found in the literature. In the young, healthy patient that sustains dehiscence or evisceration, general or spinal anesthesia can be instituted and a routine closure with or without retention sutures can be effected. In the older, debilitated patient, the added insult of general anesthesia or even sub-arachnoid anesthesia could be a fatal maneuver. It is, therefore, with the exceptionally poor risk, young or old, patient in whom anesthesia cannot be tolerated that the present procedure is recommended. However, in any case, the outcome of secondary closure is definitely aided by early recognition of the problem and immediate correction.

Doctor Hill is former Resident in Surgery, Veterans Administration Center, Dayton, Ohio, where work was completed. Presently he is Staff Surgeon, Veterans Administration Hospital, Dearborn, Michigan.

Case Reports

Case 1.—On September 19, 1962, C.H., a 54-year-old man, was admitted to the Surgical Service after an eight-day history of dull pain in the right lower quadrant, associated with nausea and anorexia, but without emesis.

Physical examination disclosed a mass in the right lower quadrant while roentgenograms showed a fecalith to be present. The patient was treated for an appendiceal abscess and taken to surgery three weeks after admission. Through a vertical infra-umbilical incision, removal of the appendix and drainage of the abscess were effected. The patient sustained a wound disruption on his sixth post-operative day, which was closed primarily by the rapid, safe closure technique under local anesthesia. Post-operatively, the patient did well and was discharged three weeks after secondary closure.

Case 2.—On January 9, 1963, C.D., a 66-year-old man, was admitted to the Surgical Service, after experiencing abdominal pain, nausea and emesis for a twenty-four hour duration. The onset of pain occurred after consuming a meal of liver and onions and was heralded by a severe episode of nausea.

Significant routine work-up disclosed icterus of the sclerae and skin, elevated serum bilirubin and a non-functioning gall bladder. The patient was taken to surgery on January 19,

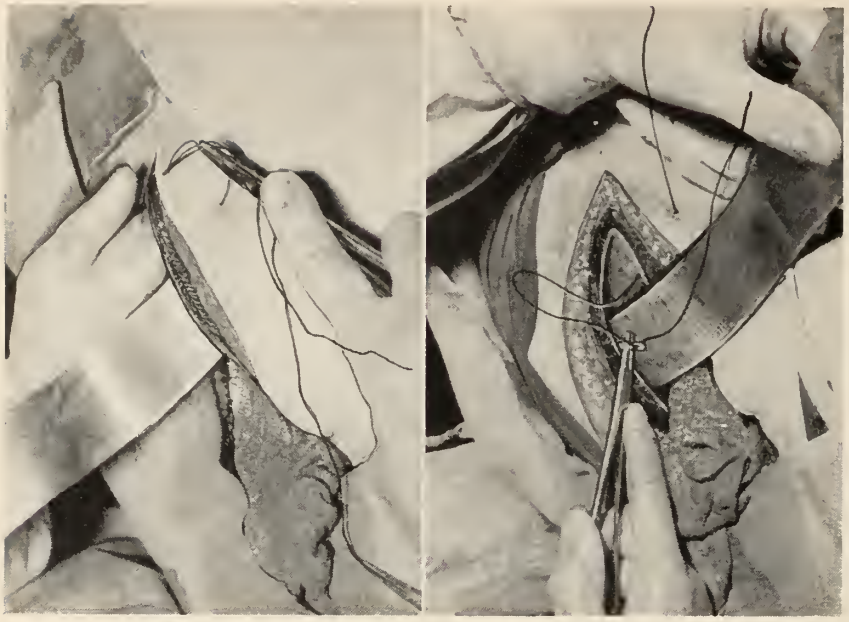


Fig 1. *(left)*. Initial passage of suture from skin through to peritoneum with malleable retractor in place and viscera protected.

Fig. 2 *(right)*. Completion of suture with passage of needle through peritoneum and out through abdominal wall with the malleable retractor guiding suture needle and protecting viscera simultaneously.

1963, and through a right paramedian incision, a cholecystectomy, common duct exploration, duodenotomy and sphincterotomy were effected. Post-operatively, the patient experienced wound disruption and a secondary closure was effected by means of the rapid safe method. After secondary closure, the patient did well and was discharged twenty-two days later.

TECHNIQUE

Pre-operative medication and sedation can be effected by any of the narcotics along with a moderate to small amount of atropine as the patient will not be asleep. The abdominal wall can be rapidly scrubbed with phisohex, cepryn and alcohol, iodine compounds or any other prepping solution, being careful not to get any of the prepping solution in the line of the evisceration or dehiscence. The area is then irrigated well with copious amounts of warm saline. Skin sutures, if present, may be removed now or after anesthetization. Anesthetization is effected by infiltration of 0.5% Xylocaine into the abdominal wall. Infiltration can be started at either apex of the wound in the subcutaneous or subcuticular area and gradually deepened and widened until the entire abdominal wall is liberally infiltrated down to the peritoneum. The abdominal viscera can be protected by a laparotomy sponge or the hand of an assistant. A malleable retractor is then placed directly beneath the peritoneum at the site where the needle is to be passed. At this time, retention sutures of either No. 4, woven black silk; No. 22, 23 or 24, stainless steel wire; or even 0, stainless steel surgiloy on a large needle can be passed through the entire abdominal wall directly to the malleable retractor (Fig. 1). The needle point is then grasped and the malleable retractor placed over the viscera, beneath the peritoneum where the adjacent side is to be sutured. With the malleable retractor protecting the abdominal viscera on the opposite side, the suture is passed through the side of the incision from the peritoneum out through the skin (Fig. 2). This maneuver completes a suture. The sutures are tagged and after enough have been placed at 1 to 1.5 cm. intervals, strips of gauze or ABD packing are laid vertically over the wound. This will require between eight and ten, four by eight gauzes or two or three ABD pads. The sutures or wires are then brought together over the gauzes or packing (Fig. 3). An overall dressing can be applied or the wound left open with



Fig. 3. Abdominal wall after closure with sutures tied in place over the protective gauzes.





Fig. 4 *(left)*. Abdominal wall after closure without protective gauzes showing the hideous cross hatching and excoriation.

Fig. 5 *(right)*. Abdominal wall after utilization of gauze squares as protection with removal of sutures being effected 18 days after closure.

daily applications of a topical germicide around the sutures at the skin juncture. The sutures should be left in place from sixteen to twenty-one days.

COMMENTS

Secondary closure of a wound dehiscence or evisceration can be an insurmountable task and often is fatal when in the poor risk patient, general or even spinal anesthesia is used. A rapid method of closure which does not necessitate either general or spinal anesthesia can be completed in less than fifteen minutes and, if performed early, should add little to worsen the patient's condition. Indeed, secondary closure healing is enhanced by total body response to initial surgery.[2] Not having to wait for general anesthesia and other ancillary factions makes it possible to decrease the length of exposure of the wound and to minimize wound contamination while remarkably good and rapid anesthesia can be effected with local infiltration of the entire abdominal wall. If one is meticulous and concerned with obviating the possibility of hernia the fascia can be rapidly approximated in any desired manner.

The folded sponges protect the skin, obviating the hideous cross hatching (Figs. 4 and 5) of most retention sutures, even those protected by tubes of plastic or rubber. The folded sponges serve additional purposes by applying hemostatic pressure over the line of dehiscence and by decreasing dead space. If more edema than anticipated occurs post-operatively, one or two of the gauzes can be removed to alleviate the pressure.

CONCLUSION

Due to increased patient age and broadening of indications for resectability and operability in the cancer patient, the occurrence of wound dehiscence and evisceration is increasing. As no rapid technique for definitive closure without benefit of general or spinal anesthesia is described, we have presented a procedure for rapid closure of wound disruption in the poor risk patient. This procedure can be carried out safely and rapidly with little discomfort to the patient.

ACKNOWLEDGMENT

The author wishes to make acknowledgment to Flavous J. Van Dyke, VA Center, Dayton, and Miss Mary Maciel, U. of Cincinnati Medical School for the photography.

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Extent And Scope Of Coverage

BY GEORGE W. SLAGLE, M.D.

THE EXTENT AND SCOPE OF health service protection in the United States today was undreamed of by the most enthusiastic advocate of private health insurance twenty years ago.

While some forms of health insurance have been available for many years, for practical purposes the main growth has taken place since 1942. Several factors combined to give the impetus to this rapid development. The introduction of Blue Cross and Blue Shield plans in the thirties, the wage and salary freeze of World War II and the coincident acceleration of medical research were all potent factors. Postwar developments have included continued rapid progress in medical and allied services, serious increases in the cost of medical services, and a greater awareness by the general public of the desirability of making advance provision for the economic costs of ill health.

The explosive growth of health insurance, however, has not come as an unmixed blessing. There have been serious problems, and the patterns of coverage which have developed represent, at first glance, a crazy quilt of an innumerable variety of policies. To many, health insurance still suggests the classic example of insurance which "provides in the large print that which it takes away in the small." Much of this negative attitude, undoubtedly, was richly deserved in the early years of the "business" development, but the situation has changed. The combined pressures of internal and external regulation plus the rigors of competition have eliminated most of the abuses which were present in the earlier years.

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EXPERIMENTATION AND CHANGE are still the hallmarks of health service protection, but the development is on a higher plane now, with the emphasis on designing coverages which more effectively meet the needs and demands of the public.

Some figures released by the health insurance council for the end of 1962 highlight the phenomenal growth of voluntary health insurance in recent years. As of that date (the latest available year-end statistics), over 141,000,000 Americans have some form of voluntary health insurance.

The breakdown on this figure was as follows: 141,000,000 had some type of protection against hospital costs; 131,000,000 had protection against certain surgical costs; and 98,000,000 were protected against specified medical care costs other than surgery. Of the 141-plus million covered by hospital insurance, 93 per cent were also protected against surgical expense, and 69 per cent had regular medical expense protection. In addition, 38 million were protected by major medical expense insurance and 43.5 million were covered by loss-of-income insurance.

These figures have even greater significance when it is noted that in 1942 only 19.7 million had protection for hospital expenses; only 8.1 million had protection against surgical expenses; and only 3.2 million had protection against regular medical expenses. Major medical insurance was not even a dream in 1942. Thus, at the end of 1962, seven times as many persons were protected against hospital expense as at the end of 1942; 16 times as many were protected against surgical expense; and 30 times as many against regular medical expenses.

The health insurance institute estimated that health insurance benefit payments during 1963 totalled $7.8 billion, an increase of 10 per cent over the record $7.1 billion paid out in 1962. The American people received these benefits from some 1,800 voluntary insuring organizations, including 859 commercial insurance companies, 77 Blue Cross plans, 70 Blue Shield plans, and nearly 800 other independent-type health plans. Insurance companies paid more than $4.1 billion of the 1963 benefits, the institute estimated.

This figure was up from the nearly $3.8 billion paid out in 1962 and represented a 300 per cent increase over the $1.1 billion in benefits paid by insurance companies during 1952, a decade earlier. Blue Cross-Blue Shield and other hospital medical plans accounted for $3.7 billion of the 1963 benefits —also an increase of 400 per cent from a decade ago.

These figures indicate clearly the dynamic nature of the movement toward voluntary prepayment

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Presented April 19, 1964, at the 9th Regional Conference on Insurance and Prepayment Plans by American Medical Association in Atlanta, Georgia. Doctor Slagle is Vice-Chairman on the "Committee on Insurance and Prepayment Plans" of the American Medical Association.

for health services. The most rapid growth in this area took place during the post-World War II years and in the early fifties. As more and more people became insured, of course, the yearly rate of increase in the proportion of the population covered has decelerated.

* * *

EVEN SO, THE SATURATION point has yet to be reached. A recent report by the assistant director of research for the Health Insurance Association of America notes that, of the 184,556,000 people in the United States at the end of *1961*, 48,034,000 were without hospitalization insurance. Of this group, some 18,600,000 persons can be considered out of the market for health insurance. These are public assistanee recipients, the institutionalized, members of the armed forces and their dependents, Indians on reservations, or veterans with serviee-connected disabilities. Individuals in these categories are eligible for governmental assistance in meeting health care eosts. They are either in no need of voluntary health insurance, or they are economically incapable of purehasing it.

The remaining 29,434,000—15.9 per eent of our total population—could be considered potentially in the market for health insurance. However, of this 15.9 per cent, an estimated one to six per cent do not want such coverage because of affluent personal circumstances, religious convictions or other reasons.

In other words, by the end of 1961, from 85 to 90 per cent of the United States population either desiring or in need of health insurance had already been covered, and coverage remained to be extended to some 10-15 per cent of our population. Blue Cross and Blue Shield plans, as well as private insurance companies are, therefore, continuing to make coverage available to more people as well as expanding the scope of protection available in individual policies.

* * *

THE STATISTICS JUST quoted are impressive, no doubt, but if taken alone, they are misleading. Far more important than the number of people with an insurance policy is the extent of coverage which they receive from the policy. Some indication of this may be taken from data compiled by the health insurance institute. According to their figures, the 7.8 billion of benefits paid by all voluntary insuring organizations in 1963 was applied to total health care costs of $21.9 billion for the same year.

These total costs represented, for the most part, charges for essential medical services, though some items such as non-prescription drugs, eyeglasses, and luxury hospital accomodations were also included. These latter items are generally considered to be uninsurable, but they represent a minor segment of total health care costs.

It is clear that the relationship between total costs and total benefits is not as favorable as the relationship between total population and total number of insureds.

According to figures published in the December, 1963 issue of the *Social Security Bulletin*, 65.6 per cent of the private consumer expenditures for hospital care only were met by insurance proceeds in 1962; only 33.6 per cent of private consumer expenditures for physicians' services were covered. When the two eategories are combined, insurance provided for slightly over 50 per cent of the costs.

It is true, of course, that private insurance should not be expected to cover all expenditures, but it should probably provide for considerably more than half of them.

Now that we have looked at the big picture, I would like to direct your attention to some specific aspects of the scope of health insurance coverage. We will examine, briefly, the five major types of health protection which are currently available, and comment on a few of the highlights.

* * *

HOSPITAL INSURANCE REMAINS the most common type of health insurance protection today. Now, as in the past, a wide variety of plans are available, but the traditional split between the "service benefit" plans of the Blue Cross organizations and the "dollar benefit" plans of commercial insurers continues as the main distinction. Within these two categories, however, several observations stand out. In recognition of the changing cost pieture of recent years, insurance companies now offer much higher daily benefits than in the past. Reimbursements of $20 per day and more are now fairly common. The "Blues," on the other hand, normally provide full service in semi-private accommodations. In addition to higher daily benefits, basie hospital policies offered by all types of carriers tend to provide for more prolonged confinements than in the past, with benefits most commonly varying from 70 to 120 days.

The scope of coverage of hospital extras or ancillary services is also broader than in the past, while the basic difference in philosophy of coverage persists between the major types of insurers. Insurance companies now tend to provide benefit reimbursement to a stated limit—usually a generous multiple of the daily hospital benefit. Blue Cross, on the other hand, usually provides benefits for specific types of service up to a scheduled limit. This latter approach is slightly less flexible.

Signifieantly, hospital insurance has become more liberal in a number of other areas in recent years. Examples include the more frequent coverage of mental disorders where treatment is in a general hospital, and the gradual disappearance of or liberalization of air travel exclusions. These two developments are a reflection of consumer demand and greater familiarity with the exposures involved. Other important developments include the pro-

More than 141 million Americans have some form of Voluntary Health Insurance. In 1942, only 19 million had some form of protection, mainly protection for hospital expenses. During 1963 Health Insurance Benefits totalled 7.8 Billions of Dollars, paid out by 1,800 voluntary insuring organizations. Instead of the limited Major Surgical Procedures granted in 1940, we now have policies that provide a full scope of Surgical Procedures, Inpatient Medical Care, Consultative Services, Treatment of Mental Disorders in a General Hospital and higher daily costs. Major Medical and Comprehensive Medical Expense Plans have a very important place in today's coverage. Pilot studies are being made on Paid-up-at-65-Policies. Income Replacement Contract is the most rapidly growing form today.

vision of limited out-patient benefits and increasing interest in nursing-home coverage. The interest in the latter two areas is primarily a reaction to the tremendous cost pressure of recent years. It is hoped that these coverages will alleviate the alleged over-utilization of high cost in-patient treatment which has resulted from policy exclusions.

* * *

SURGICAL AND MEDICAL INSURANCE now also cover a majority of the U. S. population. In the case of surgical coverage, there is less difference between Blue Shield and insurance company plans than was true under hospital coverage. Very few full-service plans are available today. A variety of surgical schedules are available, and under the partial-service plans which typify Blue Shield the income of the insured will determine the schedule to be used. In practice, a sizable but undetermined number of schedule and partial-service contracts will in fact provide full coverage.

Medical benefits create more controversy than the other coverages. The prospect of hospital confinements or surgery is sufficiently distasteful to most people to act as an effective guard against "moral hazard." A visit with a doctor is not usually so fearsome. Medical benefits are usually provided for in-hospital visits of a physician. Less commonly, total disability medical and non-disability medical is provided. These coverages usually provide for home and office as well as hospital calls. Total disability is, at best, difficult to establish, and this coverage is usually limited to employed individuals. Medical coverages frequently use deductibles and normally have daily and period maximums, for example, $4 per day for not over 100 days. Though controversial from the standpoint of the insurer, these plans are increasingly popular with the public.

The plans discussed so far suffer from the common fault of not adequately meeting the costs of serious illnesses. To meet this problem the insurance companies have developed, particularly since the 1950's, major medical and comprehensive medical expense plans.

Major medical coverage closely follows the theoretical model of insurance, providing protection against serious loss while eliminating coverage of small, routine health care expenditures. These policies are characterized by initial deductibles, most commonly in the $200-$500 range, followed by a percentage participation, typically 75%-80%, up to very high limits, often $10,000 or more. Another characteristic of these policies is that there are very few internal policy limits. The assumption is that the expense is just as serious whether it be related to hospital services, nursing care, blood transfusions, or any other health expense. Some internal limits, such as daily hospital maximums, have become necessary to prevent abuse of the coverage however.

Major medical coverage is dominated by commercial insurance companies, but an increasing number of Blue Cross and Blue Shield organizations are offering somewhat comparable benefits through their extended benefit plans—which might be more accurately likened to comprehensive medical insurance. These plans, in effect, combine basic and major medical benefits in one master contract. The deductibles are usually smaller than in regular medical insurance, and they are often applied selectively. In other words, the deductible will not apply to all expense items, and it may also vary in size for different items.

* * *

MOST OF MY COMMENTS have been directed at the offerings of commercial insurance companies and Blue Cross-Blue Shield organizations, but the so-called independent plans also offer all of the coverages which have been discussed. Time precludes extensive investigation of these plans, but suffice it to say that some of them are very comprehensive.

The final type of health insurance is the income replacement contract. This field is one of the most

rapidly growing today. An increasing variety of plans are available, but again the trend is toward protection against catastrophic, long-term, sometimes lifetime, benefits are becoming more common, as are longer initial waiting periods. The greater waiting period, in addition to lowering premiums, recognizes the fact that accumulated vacations, sick leave, and *ad hoc* or informal salary continuation tends to eliminate the need for first-day coverage. Another feature of these policies is the increasing liberality of policy definitions of total or partial disability—the primary conditions for recovery.

A serious shortcoming of most existing policies is that they drastically limit the recovery from disability resulting from sickness as opposed to accident. This is unfortunate, since there is a far greater liklihood of disability arising from sickness or disease. This is an area which needs greater development.

Other features of income replacement insurance usually include scheduled benefits for dismemberment and death—frequently with double indemnity for accidental death. Finally, underwriting requirements usually put a limit on the amount of recovery in relation to earned income prior to disability. There has been much controversy on this point over the years, but some standardization seems to be developing recently.

Having touched briefly on each of the major types of health insurance, some general observations can now be made. It should be evident that the scope of benefits provided under any of the policies discussed is directly related to the price of the protection. The old cliche that "you get what you pay for" is nowhere more true.

A less evident fact is that group insurance coverage is almost always more liberal than individual contracts. In addition to lower costs, there are usually fewer exclusions and frequently more liberal insuring agreements. Much of this can be traced to the combination of underwriting controls and buying power which is available to most large group policyholders. Another key factor is that large groups can be experience rated.

* * *

THUS, IN A VERY REAL sense, group insurance plans can be virtually tailormade to the order of the policyholder. This affords real opportunities to broaden the scope of coverage. One example is the negotiation of major medical insurance with a co-insurance cutoff. Several large employers have major medical contracts which pay 100% of all expenses up to the face amount of the policy after the sick or injured employee has paid an initial deductible plus 20% of (for example) the next $1,000. Many other examples could be cited.

One of the major accomplishments of group insurance has been the broad extension of substantial health service protection to non-employed citizens through the mechanism of dependents' coverage. This factor, perhaps more than any other, accounts for the extent of protection in this country today.

In discussing the scope of coverage available today it is impossible to ignore the tremendous strides made in the last ten years in providing protection for the senior citizens of the nation. These include special elderly groups, the so-called "state-65 plans," the "golden-65" and similar plans offered by individual companies, group insurance conversion privileges, guaranteed renewable and non-cancellable policies issued at younger ages, and some available paid-up at 65 policies. The last-mentioned development is one of the most talked about. While it faces tremendous problems, it probably is the most desirable long-term solution to the provision of health service protection for the aged.

Guaranteed renewable and non-cancellable policies, of course, improve the scope of protection for all insureds, not just the aging. They eliminate the danger of removal of protection as the result of poor claims experience.

The Committee on Insurance and Prepayment Plans was originated to help formulate plans for offering sound and constantly improving voluntary health insurance to the citizens of the nation. My job has been to describe where we stand with respect to the extent and scope of health service protection in the United States. To summarize, like the gangling, clumsy teenager who suddenly, seemingly miraculously, blossoms into a well-coordinated basketball star, health insurance and pre-payment plans are today emerging from the near-chaos of their "adolescent years" into the full bloom of maturity.

* * *

THOUGH HEALTH SERVICE protection in this country grew like Topsy, we find that a comprehensive pattern of protection has emerged. The mistakes and problems which have plagued the field have more often than not been the result of over enthusiasm and too-rapid growth; sometimes the failure to recognize yesterday's problems until tomorrow has also been at fault.

Further mistakes, innovations, and triumphs undoubtedly lie ahead, but the most serious growing pains are now history. The only real limitations on the ultimate scope of coverage are the desire and willingness of the public to pay for the product, and the courage and imagination of the industry to satisfy the demands which it will face.

AMA Clinical Convention
Miami Beach, Florida
Nov. 29-Dec. 2

MSMS Centennial Series

1941-42 Efforts Centered on War and Defense

MSMS attention was focused in 1941 on the great job of providing medical officers for the armed forces. In December, Michigan was faced with the procurement of 100 medical officers—and it was reported that the next quota would be for 700 more.

* * *

THE FOLLOWING WORK was done by the House of Delegates at the 1941 Annual Meeting:

1. Modernized the MSMS Constitution and By-Laws.
2. Recommended the rehabilitation of rejected draftees.
3. Renewed the MSMS Charter for another 30-year period of activity.
4. Created a Section on General Practice.
5. Adopted the reports of the MSMS Committees.
6. Elected progressive practitioners of medicine to the various MSMS offices.
7. Registered a vote of confidence in Michigan Medical Service.

* * *

MICHIGAN MEDICAL SERVICE reported that during its first year, services were rendered for more than 9,200 patients for which 1,694 doctors received over $300,000. A total of 3,439 doctors of medicine had completed their registration with Michigan Medical Service. At the end of the year, there was a total of 131,127 subscribers.

The 1941 House of Delegates also adopted the basic principle that the pre-payment plan to be sponsored by the medical profession should not be another insurance cash indemnity arrangement, but should be a direct service arrangement. A schedule of benefits, which is equivalent to the prevailing charge by doctors in Michigan for persons whose income ranges from $1500 to $1700 annually, was carefully set up through the cooperation of numerous committees in the various fields of practice.



P. R. Urmston, M.D.
MSMS President, 1940-41



H. R. Carstens, M.D.
MSMS President, 1941-42

The following Postgraduate courses were offered in Detroit: Allergy; Anatomy; Diseases of the Blood and Blood-forming Organs; Diseases of the Genito-urinary Tract; Diseases of the Heart, Electrocardiograph Diagnosis; Gastroenterology; Laboratory Technique; Nutritional and Endocrine Problems; Ophthalmology; Pathology; Pediatrics; Proctology; Roentgenology. Extramural courses included the care of the injured; the diagnosis and treatment of meningitis; useful drugs in gastroenterology; digestive derangements; the significance of albuminuria; office gynecology and clinical conference.

* * *

AT THE SEPTEMBER meeting in Grand Rapids, The Council voted to underwrite the establishment in 1942 of five Postgraduate Medical Conferences in the Upper Peninsula similar to those now in existence in the Lower Peninsula.

* * *

SINCE THE BASIC Science Law, which was passed by the Michigan Legislature in 1937, became effective, three examinations have been held by the Board. Two individuals wrote the first examination given on March 29-30, 1940, and both failed to pass. On June 28-29, 1940, the second examination was given to 76, of whom 53 passed and 23 failed. The third examination was given on February 14-15, 1941. Forty were examined and 35 passed.

A new bill was introduced into the U. S. Congress —the Brown-Wagner-George Hospital Construction Bill. The purpose of the bill was to offer grants-in-aid to assist state and other political subdivisions in constructing, improving, and enlarging needed hos-

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The Author
WILLIAM J.
STAPLETON, JR., M.D.
MSMS Historian

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D, Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

pitals especially in rural communities and economically depressed areas.

The MSMS annual meeting was held at Grand Rapids, September 16-19. Thirty out-of-state authorities spoke and over a hundred exhibits were shown. A total of 2,117 persons were registered (not including members of the Woman's Auxiliary).

* * *

THE MICHIGAN SOCIETY of Anesthetists was organized May 22, 1941, in Ann Arbor. Standing committees on education, public relations, and legislation were created.

The 55th county society charter was granted in 1941 to the Huron County Medical Society.

The Council began holding Councilor District Meetings, to replace meetings known as State Society nights.

* * *

Before taking up the history of the Michigan State Medical Society for 1942, I would like to say a few words about Doctor Carstens, who was President that year. In my space I can only give you a thumbnail sketch of the illustrious son of a famous father. (His father was a nationally-known abdominal surgeon and gynecologist of his day. "Dad" Carstens was the affectionate title given him by the students. His story would make a book in itself.) His son, Henry, did not follow in his father's footsteps as a surgeon. After graduation and internship at Harper Hospital, he soon established himself as an internist. He was elected President of the American College of Physicians, served in World Wars I and II, and also held various other offices in the medical societies. He received numerous commendations for his medical work in the Army Corps. After the end of World War II, he entered the Veterans Administration and served there until he was released recently. He was a man who not only served his country well, but medicine also.

* * *

THE IMPORTANT MATTERS in 1942 were the war and defense efforts.

The MSMS Medical Preparedness Committee was active in encouraging the procurement of 800 medical officers. Approximately 200 Michigan doctors have joined the armed forces in the past year.

Hundreds of physicians devoted their time to teach first aid to thousands of men and women needed for Michigan's Civilian Defense.

Early in May, the Army set up a Medical Recruiting Board in Michigan, which processed applicants for appointment and granted the commissions on the spot. Through this streamlining of medical recruitment, commissions were granted in a matter of days.

An institute on "Medical Practice in Total War" was presented as part of the Annual Meeting Program by the MSMS Preventive Medicine Committee, in Grand Rapids.

Military membership in the MSMS was granted to members in good standing with their state dues paid during the period of such active service if recommended by the county medical society.

February 28 marked the completion of the second year of operation of Michigan Medical Service. On November 30, 1941, the enrollment reached 450,000. During the first year $200,000 was paid to doctors for services to subscribers. A total of 3,489 doctors were participating.

The membership for 1941 was 4,495, a gain of 17 members.

* * *

THE MICHIGAN WOMAN'S AUXILIARY had 1,257 members. During the past year, the following activities have been accomplished:

1. Hospital Insurance for Physician's Widows (individual contacts) set up.
2. Set up a Student Loan Fund and provided for its administration.
3. Publication of a State Bulletin.
4. Organized Auxiliaries in three new counties.
5. Sponsoring jointly with the Michigan Tuberculosis Association a High School Radio Contest.

POSTGRADUATE PROGRAMS were offered at Ann Arbor, Bay City, Flint, Cadillac, Grand Rapids, Kalamazoo, Lansing, Mt. Clemens, Sault Ste. Marie, Marquette, Houghton, Ironwood and Powers.

Following instructions from the 1941 House of Delegates, the Executive Committee empowered the president of the State Society to sign the trust agreement creating the "MSMS Foundation for Postgraduate Medical Education" on June 18, 1942, in Detroit. The trust fund was to be devoted to the development of a greater Michigan postgraduate medical program.

Detroit and Wayne County were the starting points of Michigan's emergency immunization campaign to protect children over 9 months and under 10 years of age against diphtheria and smallpox.

'Michigan Made Medical Miracles' in Spotlight

". . . while it is quite a well-known fact that our major drug and pharmaceutical companies, our universities and research laboratories make outstanding direct contributions to the world's supply of miracle drugs and medicines, the contributions in the field of medicine and surgery that have been made by our major industries are less well known."

So declared "Michigan Challenge," the official publication of the Michigan State Chamber of Commerce, in its May issue, dedicated to "Michigan Made Medical Miracles."

The introductory editorial also pointed out that drugs, mechanical hearts, mechanical heart valves, synthetic arteries, artificial ears, food pumps and other mechanical aids to surgeons, "have been created by our major industries with research and development costs written off for those items as Michigan industry's contribution to humanity."

Abstract of MSMS Council Action

Meeting of May 20, 1964

MICHIGAN CONGRESS ON MENTAL HEALTH

Final plans of the Mental Health Committee for the Michigan Congress on Mental Health were approved. The Congress was scheduled for June 26 at the Statler-Hilton Hotel in Detroit, with both medical and lay leaders in mental health invited.

REVISION OF UNIFORM FEE SCHEDULE FOR GOVERNMENTAL WELFARE AGENCIES

The Council requested the committee working on the fee schedule revision to update the schedule based on the policy that wards of government be not treated as indigents and that physicians be compensated by the usual and fair fees for their services.

MICHIGAN MEDICAL SERVICE PROPOSAL ON MERIT RATING

The Council requested additional information on this subject prior to the Midsummer Meeting of The Council.

PROPOSED TRANSFER OF PHYSICIAN SERVICES TO BLUE CROSS BENEFITS

The Council in a telegram to Michigan Hospital Service and the Michigan Hospital Association vigorously opposed the proposed Michigan Hospital Service policy regarding anesthesia services as Blue Cross benefits. In addition, this matter was referred to the MSMS Hospital Relations Committee for liaison action.

PROCEDURES FOR PROPOSED UTILIZATION COMMITTEE

As requested by The Council, Legal Counsel presented his legal opinion regarding the report of the Ad Hoc Committee to Study Procedures for Utilization Committee. Inasmuch as implementation of the Committee's recommendations requires amendment of the Bylaws, this matter was referred to the House of Delegates Committee on Constitution and Bylaws.

MSMS MATERNAL HEALTH CONFERENCE

The success of this two-day educational conference at Gull Lake was reported. The meeting was sponsored by the MSMS Maternal Health Committee, W. W. Jack, M.D., Chairman, and the Michigan Department of Health.

ADVERTISING FOR MICHIGAN MEDICINE

The Council approved the recommendation of the Publication Committee that a Michigan advertising representative be retained on a trial basis to augment national advertising sales.

Calendar of Michigan Medical Events

September 20-25—Michigan State Medical Society House of Delegates and Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit

September 22—Michigan Medical Service Annual Meeting, Ballroom, Sheraton-Cadillac Hotel, Detroit

September 22-24—Woman's Auxiliary to MSMS Annual Meeting, Pick-Fort Shelby Hotel, Detroit

September 23-24—Michigan State Medical Assistants Society Annual Meeting, Statler-Hilton Hotel, Detroit

October 15-17—University of Michigan Medical Center Alumni Conference, Ann Arbor

October 16— Hospital Section of Michigan Library Association, Jack Tar Hotel, Lansing

October 18-24—"Michigan Community Health Week"

October 21-22—Michigan Tuberculosis & Respiratory Disease & Michigan Thoracic Society Meeting, Statler Hilton Hotel, Detroit

November 13-16—National Society for Crippled Children & Adults, Statler-Hilton Hotel, Detroit

November 14-15—Michigan Allergy Society, Midwest Forum on Allergy, Henry Ford Auditorium, Detroit

Offer Smoking-Health Brochures

The initial response to a mailing on July 17 about smoking and health has been enthusiastic and a supply of literature is being mailed to many doctors as part of a new educational effort of the MSMS Cancer Control Committee and the Michigan Cancer Coordinating Committee.

An order blank for such material was sent to every doctor – and dentist – by the MCCC. A stamped, addressed envelope back to MCCC, Box 152, East Lansing, was enclosed. Packets of five different booklets and folders are offered to doctors for their offices.

Any doctor, who did not return the order blank, may obtain the educational materials by writing to MCCC, Box 152, East Lansing.

The 1963 MSMS House of Delegates action to "publicize the harmful effects of cigaret smoking and to promote an educational program" was endorsed by the recent AMA House of Delegates in San Francisco.

The AMA House of Delegates approved a strong stand on tobacco and health by calling cigaret smoking "a serious health hazard." The delegates also voted that the AMA be "on record and does recognize a significant relationship between cigaret smoking and the incidence of lung cancer and certain other diseases."

In Michigan, MSMS efforts are concentrated with the Cancer Control Committee (Henry J. Vanden-Berg, Jr., M.D., Detroit, Chairman) and the Michigan Cancer Coordinating Committee, of which MSMS is a member. The current educational effort was proposed by the MSMS Committee and adopted by MCCC.

Paregoric to Require Prescription August 28

According to legislation passed in the 1964 Session of the Michigan Legislature, paregoric, alone or in combination, may be dispensed by a pharmacist only upon receipt of a prescription, as of August 28.

A new law which will take effect August 28, 1964, provides for either a written or oral (telephone) prescription from a licensed physician or dentist in order for a patient to obtain the drug.

The previous law permitting over-the-counter sale of two ounces of paregoric in a 48-hour period has been repealed by this new Act.

Also, a provision in the new law will require physicians and dentists to keep complete records as to purchase and sale of any paregoric dispensed by the physician or dentist.

Decide Today

To Participate In

99th Annual Session,

In Detroit,

September 23-24-25

AMA Adopts MSMS Plea For Auto Safety Study

Automobile safety will continue as a concern of the AMA –following the adoption by the AMA House of Delegates in San Francisco of a resolution introduced by the Michigan delegation.

The delegates approved "Resolution No. 49" introduced by MSMS President Orlen J. Johnson, M.D., one of the Michigan delegates, and reported out favorably by the Reference Committee on Public Health and Occupational Health. The resolution, passed by the delegates, was sent to the AMA Board of Trustees "for implementation."

The Michigan resolution reviewed by the fine work to reduce auto deaths and injuries by "the automobile manufacturing industry, highway, engineers, enforcement officials and the medical profession." He then cited continuing problems.

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The action part of the resolution declared:

"Therefore be it RESOLVED that the American Medical Association continue to support and encourage expanded research in the proper packaging of the human body in the automobile and the degree of protection offered by seat belts, improved door latches, energy absorbing steering wheels, padding, etc., and present such finding to the automobile industry and others vitally concerned."

The Reference Committee suggested that "All physicians are urged to report to the AMA the results of studies which could provide better information to automobile designers in the attempt to further improve safety equipment."

The MSMS Committee on Highway Accident Prevention (John R. Rodger, M.D., Bellaire, Chairman) has an outstanding record of public service in this field. MSMS members participated with Cornell University in a crash injury research program at its outset in 1957-61 and are now taking part in a follow-up study in Michigan.

A complete report of the AMA House of Delegates will be presented by the MSMS delegation to the MSMS House of Delegates in September. Detailed news articles about the San Francisco session appear in the July 6 number of the AMA News.

Aging Health Suggestions Listed

"Aging is not synonymous with ill health."

That is the opening sentence in the report of the Health Task Force to the Michigan Commission on Aging, presented to Governor Romney and the Commission at a day-long conference at the University of Michigan, July 1.

The opening paragraph went on to state that "With the medical knowledge now at our command, most persons can look forward to good health in their later years. Many of the older persons who once might have been regarded as hopelessly disabled now can be made relatively healthy and independent."

The introduction to the Task Force Report suggests that many of the concerns of the aging "are interrelated." The introduction points out that Michigan's population will total around 8,457,000 by the end of 1964 with about 710,000 over 65—with the figures increasing by 1970 to 9,250,000 total and 802,000 over 65.

Following are the recommendations made by the Health and Mental Health Task Forces:

HEALTH

A. Periodic health appraisal of the aged and aging should be: 1. Paid for by the Department of Social Welfare for all public assistant clients; 2. Provided through multiple screening programs operated jointly by health departments, the medical profession and voluntary agencies; 3. Included as benefits by prepaid medical insurance programs.

B. Prepayment hospital and medical plans should be: 1. Provided to retirees and their spouses without payment through paid-up plans financed through their work years; 2. Extended and expanded to give more comprehensive coverage, including home care.

C. Comprehensive home care programs should be: 1. Established throughout the state; 2. Covered by pre-paid health insurance programs; 3. Paid for, including homemaker services, by the State Department of Social Welfare.

D. Care for the chronically ill in institutions should be improved by: 1. Improving standards through a new classification system; 2. Extending licensing and supervision to all (including small homes) by a single agency of state government; 3. The State Commission on Aging encourage by all possible means the construction of high-quality, long-term care facilities.

E. That preventive services be made available throughout the State by: 1. Passing legislation requiring approved full-time local health services in all cities; 2. Substantially increasing state subsidies to local health departments.

MENTAL HEALTH

It is recommended that a multi-disciplinary training and research institute be established associated with the University of Michigan and Wayne State University for solving the complex problem of training professional and auxiliary personnel needed in programs for the aged. It also would serve the needs of much needed research.

Increased emphasis should be placed on Day Care Programs and halfway houses to prevent long-term hospitalization or institutional residence.

Special funds should be allocated from state appropriations utilizing matching federal funds, for retraining of personnel in county medical care facilities, nursing and convalescent homes.

The treatment and rehabilitation program in county medical care facilities should be geared towards active rehabilitation with a strong orientation towards returning the individual to his home.

AMA re Chiropractic:

During a hearing before the Special Subcommittee on Federal Employees' Compensation of the Senate Labor and Public Welfare Committee on S. 1710 and S. 2078 which would authorize chiropractic care of injured Federal employees under the provisions of the Federal Employees Compensation Act, AMA Executive Vice President F. J. L. Blasingame, M.D., stated AMA's strong opposition to chiropractic.

"Chiropractors are not educated or equipped, either by background or training, to diagnose human illness. This inability, coupled with their pseudoscientific method of treatment and their vociferous stand against life-saving vaccines and the well-recognized advances of the medical profession in the control, diagnosis, treatment, and prevention of disease requires, or perhaps demands, that no consideration be given to them."

In concluding his remarks, Doctor Blasingame stated that "We believe that the enactment of S. 1710 or S. 2078 would be neither in the public interest, nor in the interest of those federal employees who might mistakenly seek the services of a cult practitioner, rather than the sound, scientific advice of qualified physicians."



The story about the first MSMS Michigan Congress on Mental Illness and Health, which drew 288 in Detroit (shown above), will be described at the AMA Second National Congress on Mental Illness and Health at Chicago, November 5-7. Recommendations of the Michigan Congress will be considered at the next meeting of the MSMS Mental Health Committee.

NEWS BRIEFS:

He Who Runs May Read That...

SAN FRANCISCO—The AMA House of Delegates in San Francisco re-elected William A. Hyland, M.D., Grand Rapids, chairman of the MSMS delegation, to the AMA Council on Constitution and Bylaws.

* * *

EAST LANSING—"School and community persons interested in health projects should work through their county medical societies."

That advice was given by an MSMS spokesman at a Michigan State University Workshop on School Health, July 31.

The "Statement of the AMA Council on Foods and Nutrition" and AMA kits on "Food Fadism" were distributed to the participants.

* * *

REGINA, SASKATCHEWAN—The Saskatchewan Minister of Health reports that the cost of medical care rose 14 per cent in the first quarter of 1964.

Based on the first-quarter cost, the Minister expressed the fear that the 1964 total costs might reach $23,000,000—as compared to $19,400,000 in 1962, the first year of the government plan.

ANN ARBOR—More than 150 incoming residents and interns at the University of Michigan Hospital during a two-day orientation on the practice of medicine in Michigan heard three MSMS and county society leaders. The speakers were MSMS President Orlen J. Johnson, M.D., Bay City; Otto K. Engelke, M.D., head of the Washtenaw County Health Department and a Past President of the State Medical Society; and Robert F. Powers, M.D., President of the Saginaw County Medical Society.

* * *

DETROIT—The Michigan Blue Cross Board of Trustees has elected Bennett J. McCarthy to a new position of vice president and general manager. He formerly was assistant general manager.

The Board also has elected Allen R. Schaedel, director of finance as treasurer. He succeeds Ralph E. Phelps, who was both the corporation treasurer and a board member. Mr. Phelps, who will retain his Board position, is assistant secretary of the S. S. Kresge Co.

Time to Study Candidates, Now; Primary, Sept. 1

On September 1, Michigan voters will go to the polls to participate in one of the most important Primary Elections in years.

Between now and September 1, the voters must familiarize themselves with the candidates and their stands on vital issues.

This will be no easy task!

On July 21, the candidates filed for the September 1 Primary. In addition to contests for the Governor and Lieutenant Governor, the ballot will offer contests for most of the positions to be filled.

This coming Primary Election will be one of the most crucial in years because most of the state legislative districts in Michigan have been changed. As a result, a great percentage change in the make-up of the Legislature is forecast. It's anyone's guess whether the Legislature will wind up under Republican, or Democratic control and that goes for state offices from the Governorship on down.

WSU Medical School Begins New Award



MARGOLIS SCOTT

Frederick Margolis, M.D., Kalamazoo, and Gordon H. Scott, Ph.D., WSU Vice President for Medical School Development, were the only Michigan men among the five recipients of the new Wayne State University School of Medicine's "Distinguished Service Award." Doctor Scott was cited for his work at WSU, and Dr. Margolis for his concern about fluoridation and Indian health problems.

GOP Platform Quotations on Health Matters:

The national Republican party platform, adopted in San Francisco, denounces the Administration's proposal for medical care of the aging under social security:

The document, in part, states:

1. *Help in Medical Financing for the Indigent Aged:* "Tax credits and other methods of assistance to help needy senior citizens meet the costs of medical and hospital insurance."

2. *Social Security:* "A strong, sound system of social security, with improved benefits to our people. . . . Revision of the social security law to allow higher earnings, without loss of benefits by our elderly people."

3. *Improvements in Kerr-Mills Law:* "Full coverage of all medical and hospital costs of needy elderly people financed through broader implementation of Federal-state plans (Kerr-Mills) rather than the compulsory, Democratic scheme covering only a small part of such costs for everyone, regardless of need."

4. *Research, other Medical Programs:* "Continued Federal support for sound research programs aimed at both the prevention and cure of diseases, and intensified efforts to secure prompt and effective application of the results of research. This will include emphasis on illness, drug addiction, alcoholism, cancer, heart disease and other diseases of increasing incidence."

Two men educated in Michigan have been appointed to the AMA-ERF Committee of Scientific Advisors. They are D. D. Van Slyke, bio-chemist with Brookhaven National Laboratory, New York, who received his B.S. and Ph.D. at the University of Michigan; and Maurice B. Visscher, M.D., University of Minnesota medical school, who was born in Holland and received his B.S. from Hope College.

"MICHIGAN MEDICINE" CLICKS: EXCERPTS FROM THE MAILBOX

"The new format for the JOURNAL is great and the July number is an excellent one.

"So that I won't miss an issue it is about time to change my address (September 1 is about moving day) to 2689 Dupont, Jacksonville, Florida 32217. Thanks."

CLARENCE I. OWEN, M.D.
MSMS Past President

° ° °

"I have just finished reading the current (July 1964) issue of MICHIGAN MEDICINE.

"The JOURNAL is attractive in format, easy to read, and indeed informative. Both of you can be proud of the results!

"Thank you for your efforts."

HUGH T. CAUMARTIN, M.D.
Saginaw

° ° °

"Congratulations on the new make-up of the JOURNAL. The new title, 'Michigan Medicine,' is a fine one, I thought. It is certainly bright, not only on the cover but with its contents."

WM. J. STAPLETON, JR., M.D.
MSMS Historian

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"I wish to congratulate you and your Editorial Staff for the fine new format which you have presented this month of July, 1964. I certainly feel that the appearance has been much improved and will, therefore, be much more acceptable to the public and to the profession.

"Congratulations! Good Luck! —and keep up the good work!"

DONALD N. SWEENY, JR., M.D.
Editor, Detroit Medical News

° ° °

"Congratulations on your new publication. It has an attractive cover and I am sure will appeal to the membership of MSMS."

ADELAIDE K. DAVIS
Executive Vice President
State Medical Journal
Advertising Bureau, Inc.

° ° °

"Congratulations on your 'new look.'

"We were particularly taken by your four colored pages used for late breaking news.

"I think that if more of the state journals could come up looking like yours that our advertising problems would take care of themselves.

"Best wishes for many future successes."

RICHARD OMOHUNDRO
Managing Editor
Pennsylvania Medical Journal

New Mental Health Director Favors Care Near Home

The new Michigan Community Mental Health Services Act is "an excellent start in the right direction," declared Robert A. Kimmich, M.D., new director of the Michigan Department of Mental Health, in his first news conference.



"The Act is not a panacea for all mental health services," he also observed. He urged the partnerships between state and county governments made possible under the new Act "should be encouraged." Doctor Kimmich, who comes from San Francisco, where he had been director of mental health services since 1960, also stressed the importance of community mental health services and the "continuity of patient care as close to home as possible."

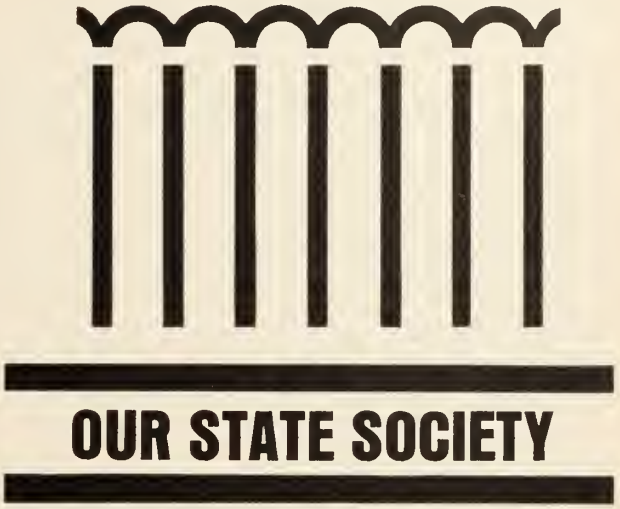
The Michigan Health Council television program over WZZM-TV in Grand Rapids recently featured Morris Wilderom, M.D., Grand Rapids, in a program about "Venereal Disease."

Official Call

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, September 20-25, 1964. The provisions of the Constitution and ByLaws and the Official Program will govern the deliberations.

ORLEN J. JOHNSON, M.D.
President
HAROLD H. HISCOCK, M.D.
Council Chairman
J. J. LIGHTBODY, M.D.
Speaker
LOUIS F. HAYES, M.D.
Vice Speaker

Attest:
D. BRUCE WILEY, M.D., *Secretary*



Official Call for 99th Annual Session Michigan State Medical Society

The 1964 House of Delegates of the Michigan State Medical Society will hold a three-day session beginning Sunday, September 20, at 8:00 p.m. The business of the House of Delegates will be transacted in the Grand Ballroom of the Sheraton- Cadillac Hotel, Detroit.

The House will also meet on Monday, September 21, at 8:30 a.m. and 8:00 p.m. and on Tuesday, September 22, at 8:30 a.m. and at 8:00 p.m.

The following pages include the House of Delegates Order of Business, Official Announcements and List of Delegates.

SEATING OF DELEGATES

"A Delegate, or in his absence, an Alternate Delegate (in order of seniority) becomes a member of the House of Delegates when duly registered and seated at the Annual Session following his election and certification by the component County Society. Once seated a Delegate shall remain a Delegate throughout the entire Session and thereafter until the next Annual Session of the House of Delegates and his place shall not be taken by any other Delegate or Alternate Delegate except that in case of emergency the House of Delegates may seat a duly accredited Alternate Delegate from the same component County Society. Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate Delegate next on the certified list furnished by his component County Society."—MSMS Bylaws, Chapter 9, Section 4.



O. J. JOHNSON, M.D.
Bay City
President



J. J. LIGHTBODY, M.D.
Detroit
Speaker



H. H. HISCOCK, M.D.
Flint
Council Chairman



L. F. HAYES, M.D.
Gaylord
Vice Speaker



D. B. WILEY, M.D.
Utica
Secretary

Order of Business:

1964 MSMS HOUSE OF DELEGATES

SUNDAY, SEPTEMBER 20, 1964
Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

6:00 p.m.—Registration
Speaker's Dinner with Reference Committee Chairmen: Washington Room
8:00 p.m.—First Meeting
1. Call to Order by Speaker
2. Report of Committee on Credentials
3. Prayer by Ralph R. Cooper, M.D., Detroit
4. Appointment of Reference Committees:
   (a) On Constitution and Bylaws
   (b) On Emergency Medical Service
   (c) On Executive Session
   (d) On Hygiene and Public Health
   (e) On Legislation and Public Relations
   (f) On Medical Service and Prepayment Insurance
   (g) On Miscellaneous Business
   (h) On Reports of Council
   (i) On Reports of Officers
   (j) On Reports of Special Committees
   (k) On Reports of Standing Committees
   (l) On Resolutions
   (m) On Rules and Order of Business
   (n) On Special Memberships
   (o) On Ways and Means
5. Speaker of the Evening—Milford O. Rouse, M.D., Speaker of the House of Delegates, American Medical Association
6. Speaker's Remarks—J. J. Lightbody, M.D., Detroit
7. Report of House of Delegates Committee on Certificates of Commendation
8. Introduction of Resolutions

MONDAY, SEPTEMBER 21, 1964
Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

8:30 a.m.—Second Meeting
9. Supplemental Report of Committee on Credentials
10. Introduction of Resolutions
11. President's Address—O. J. Johnson, M.D., Bay City
12. President-Elect's Address—Oliver B. McGillicuddy, M.D., Lansing
13. Greetings of Woman's Auxiliary—Mrs. R. J. Himmelberger, Lansing, President
14. Greetings of Michigan State Medical Assistants Society—Mrs. Dorothy Brandis, Lansing, President
15. Annual and Supplemental Annual Reports of The Council (including Annual Reports of Committees of The Council)—Harold H. Hiscock, M.D., Flint, Chairman of The Council
16. Report of Delegates to American Medical Association—Wm. A. Hyland, M.D., Grand Rapids, Chairman
17. Report of Michigan Medical Service—Sidney Adler, M.D., Detroit, President
18. Reports of Committees of the House of Delegates:
   (a) Centennial Advisory Committee
   (b) Committee on Constitution and Bylaws
   (c) Committee to Study Emergency Care in Hospitals
   (d) Committee to Study Procedure of the House of Delegates
   (e) Committee to Study Relationship Between Doctors of Medicine and Osteopaths
   (f) Committee to Study Section Representation in the House of Delegates of MSMS
19. Reports of MSMS Standing and Special Committees:
   (a) Committee on Postgraduate Medical Education
   (b) Public Health Committee
      (1) Committee on Cardiac Disease Control
      (2) Committee on Maternal Health
      (3) Committee on Venereal Disease Control
      (4) Committee on Tuberculosis Control
      (5) Committee on Cancer Control
      (6) Committee on Occupational Health
      (7) Committee on Mental Health
      (8) Committee on Child Welfare
      (9) Committee on Geriatrics
      (10) Committee on Rural Medical Service
      (11) Committee on Blood Banks
      (12) Committee on Highway Accident Prevention
      (13) Committee on Diabetes Control
      (14) Commmittee on Iodized Salt
   (c) Public Health Interim Committee
   (d) Committee on Public Relations
   (e) Committee on Ethics
   (f) Committee on Legal Affairs
   (g) Committee on Mediation
   (h) Advisory Committee to the Woman's Auxiliary of the MSMS
   (i) Advisory Committee to the Michigan State Medical Assistants Society
   (j) Committee on Professional Insurance Plans
   (k) Advisory Committee of Past Presidents
   (l) Medical Socio-Economics Committee
   (m) Committee on Scientific Radio and Television
   (n) Annual Session Program Committee

MONDAY, SEPTEMBER 21, 1964
Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

8:00 p.m.—Third Meeting
20. Supplemental Report of Committee on Credentials
21. Unfinished Business
22. Introduction of Resolutions; Other New Business
23. Reports of Reference Committees:
   (a) On Constitution and Bylaws
   (b) On Emergency Medical Service
   (c) On Executive Session
   (d) On Hygiene and Public Health
   (e) On Legislation and Public Relations
   (f) On Medical Service and Prepayment Insurance
   (g) On Miscellaneous Business
   (h) On Reports of Council
   (i) On Reports of Officers
   (j) On Reports of Special Committees
   (k) On Reports of Standing Committees
   (l) On Resolutions

FORM FOR RESOLUTIONS TO HOUSE OF DELEGATES

Each resolution introduced in the House of Delegates shall be introduced by a Delegate. It shall be in writing and presented in triplicate to the Secretary. It shall be referred by the Speaker to the proper Reference Committee before action is taken thereon. (Bylaws, Chapter 9, Section 13.)
Official printed resolution forms follow the below format:

Date_____
Introduced by:_____, M.D.
_____County Medical Society
SUBJECT: _____
Whereas, _____, and
Whereas, _____, therefore be it
RESOLVED: _____
NOTE: Each Delegate is invited to send a copy of all resolutions to Speaker J. J. Lightbody, M.D., Box 152, East Lansing.

(m) On Rules and Order of Business
(n) On Special Memberships
(o) On Ways and Means

TUESDAY, SEPTEMBER 22, 1964
Grand Ballroom, Sheraton-Cadillac Hotel, Detroit
8:30 a.m.—Fourth Meeting
24. Supplemental Report on Committee on Credentials
25. Reports and Supplemental Reports of Reference Committees
26. Unfinished Business
27. Introduction of Resolutions; Other New Business
11:30 a.m.—Awards
28. Awards:
(a) Report of Committee on "Certificates of Commendation"
(b) Fifty-Year Awards
(c) Awards to Employees (per 1961 House of Delegates)

TUESDAY, SEPTEMBER 22, 1964
Grand Ballroom, Sheraton-Cadillac Hotel, Detroit
8:00 p.m.—Fifth Meeting
29. Supplemental Report of Committee on Credentials
30. Unfinished Business
31. Supplemental Reports of Reference Committees
32. Introduction of incoming President of MSMS, Oliver B. McGillicuddy, M.D., Lansing—O. J. Johnson, M.D., Bay City, President, MSMS
33. Elections:
(a) Councilors:*
1st District—Edward J. Tallant, M.D., Detroit—Incumbent
1st District—Edgar E. Martmer, M.D., Detroit—Incumbent
1st District—Don W. McLean, M.D., Detroit—Incumbent
4th District—Don Marshall, M.D., Kalamazoo—Incumbent
5th District—C. Allen Payne, M.D., Grand Rapids—Incumbent
6th District—Harold H. Hiscock, M.D., Flint—Incumbent
10th District—Edward H. Rodda, M.D., Bay City—Incumbent
14th District—Bradley M. Harris, M.D., Ypsilanti—Incumbent
(b) Delegates to American Medical Association:
C. I. Owen, M.D., Detroit—Incumbent
G. W. Slagle, M.D., Battle Creek—Incumbent
D. N. Sweeny, Jr., M.D., Detroit—Incumbent
(c) Alternate Delegates to American Medical Association:
R. E. Rice, M.D., Greneville—Incumbent
A. Hazen Price, M.D., Detroit—Incumbent
E. E. Martmer, M.D., Grosse Pointe—Incumbent
(d) President-Elect
(e) Speaker of the House of Delegates
(f) Vice Speaker of the House of Delegates
34. Introduction of the new MSMS President-Elect—Oliver B. McGillicuddy, M.D., Lansing, incoming President, MSMS
35. Adjournment

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*MSMS Bylaws, Chapter 12, Section 1—Term of Office:
"Except as herein otherwise provided, officers shall take office immediately after the election. With the exception of Councilors, they shall serve until the next Annual Session and until their respective successors shall have been elected. Councilors elected prior to 1960 shall serve for five years. Councilors elected in 1960 and thereafter shall serve for three years, provided, however, that in the year 1963 six Councilors shall be elected for terms of three years each and three Councilors shall be elected for terms of two years each. The election of Councilors in said years shall be conducted in the usual manner as prescribed in Section 10 of Chapter 9 of these Bylaws, and immediately thereafter, the length of the respective terms to be served by those elected shall be determined by lot under the direction of the Speaker of the House of Delegates."

MSMS CENTENNIAL ONE YEAR AWAY

As September nears, MSMS leaders are looking ahead one year—to the 100th Centennial Annual Session of the Michigan State Medical Society! The 100th Annual Meeting will be held in 1965 in Detroit—where the organization was formed a century ago.

Many special highlights are being planned now for the Centennial meeting, set for September 19-24, 1965. The annual meeting will begin a year-long observance of the society's centennial.

Reservations for hotel rooms for the 1964 Annual Session should be mailed now to the Sheraton-Cadillac (headquarters hotel) or to the hotel of your choice. The 1964 dates are September 20-21-22 for the House of Delegates and September 23-24-25 for the Annual Scientific Session. Decide today to participate.

SCHEDULE OF THE GENERAL MEETING OF THE MICHIGAN STATE MEDICAL SOCIETY

Formal installation of the President of the Michigan State Medical Society will take place during a general meeting of the Society at the time of the State Society Dinner Dance:

Thursday, September 24, 1964, in the Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Presiding, O. J. Johnson, M.D., Bay City, President. Installation of New President: Oliver B. McGillicuddy, M.D., Lansing.

MICHIGAN MEDICAL SERVICE SCHEDULE

Tuesday, September 22, 1964

12:30 p.m. Luncheon, English Room, Sheraton-Cadillac Hotel

1:30 p.m. Meeting of Members of the Corporation, Ballroom, Sheraton-Cadillac Hotel

All MSMS Delegates are members of Michigan Medical Service Corporation and are expected to attend the MMS Luncheon and Annual Meeting. The MMS Annual Meeting is open to ALL members of the medical profession, who are cordially invited to attend.

Delegates and Alternates For '64 House of Delegates

SHERATON-CADILLAC HOTEL, DETROIT

SEPTEMBER 20-21-22, 1964

(Names of Alternates appear in italics)

OFFICERS

Speaker
James J. Lightbody, MD, 501 David Whitney Bldg., Detroit 26

Vice Speaker
Louis F. Hayes, MD, Gaylord

Secretary
D. Bruce Wiley, MD, 46056 Cass Avenue, Utica

Immediate Past President
Clarence I. Owen, MD, Box 569, Harrow, Ontario, Canada

ALLEGAN
Lewis F. Brown, MD, 133 E. Allegan Street, Otsego
Gerald VanderVoord, MD, 312 E. Plum St., Wayland

ALPENA-ALCONA-PRESQUE ISLE
John W. Bunting, MD, 110 First Ave., Alpena
Edward A. Hier, MD, 125 N. Second Ave., Alpena

BARRY
Robert J. Huebner, MD, 110 West Center, Hasting
Everett L. Phelps, MD, 535 E. Francis St., Hastings

BAY-ARENAC-IOSCO
Wm. G. Gamble, Jr., MD, 2010 Fifth Ave., Bay City
Robert C. Prophater, MD, 101 W. John St., Bay City
Allen B. Moore, MD, 700 Borton Ave., Essexville

BERRIEN
Noel J. Hershey, MD, P.O. Box 222, Niles
Paul O. Rague, MD, 960 Agard, Benton Harbor
F. Alan Kennedy, MD, 315 Fidelity Bldg., Benton Harbor
Frederick H. Lindenfeld, MD, 8 N. St. Joseph Ave., Niles

BRANCH
Robert M. Leitch, MD, 401 Ann St., Union City
Robert J. Fraser, MD, 22 W. Pearl St., Coldwater

CALHOUN
George T. Kelleher, MD, 235 North Ave., Battle Creek
R. C. Roman, MD, 500 S. Ionia St., Albion
K. S. Wemmer, MD, 1472 W. Michigan Ave., Battle Creek
Alfred G. McCuaig, MD, 719 Capital Ave., Battle Creek
S. A. Yannitelli, MD, 710 North Ave., Battle Creek
D. E. Boswell, MD, 105 N. Jefferson St., Marshall

CASS
Uriah M. Adams, MD, Marcellus
Sherman L. Loupee, MD, 108 Orchard, Dowagiac

CHIPPEWA-MACKINAC
Donald D. Finlayson, MD, 301 E. Spruce St., Sault Ste. Marie
Wm. F. Mertaugh, MD, 104 W. Spruce St., Sault Ste. Marie

CLINTON
Franklin W. Smith, MD, 105 S. Ottawa St., St. Johns
James M. Grost, MD, 110 Oakland St., St. Johns

DELTA-SCHOOLCRAFT
Francis C. Anderson, MD, 218 S. 10th St., Escanaba
Merle E. Wehner, MD, 131 River St., Manistique

DICKINSON-IRON
Donald T. Anderson, MD, 408 Hamilton Ave., Kingsford
William R. Gladstone, Jr., MD, 804 Main St., Norway

EATON
Byron P. Brown, MD, 319 E. Lawrence Ave., Charlotte
Clayton O. Willits, MD, 141 S. Washington, Charlotte

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Wm. R. Purmort, MD, Newberry State Hospital, Newberry

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Charles L. Oppy, MD, Roscommon

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DUTIES OF HOUSE OF DELEGATES COMMITTEES EXPLAINED

Ad Hoc Committee To Study the Procedures Of the House of Delegates

The 1963 House of Delegates authorized that the Speaker of the House appoint an Ad Hoc Committee of the House of Delegates "to determine if revisions are necessary so that the House of Delegates may operate more efficiently," and to report at the 1964 Session.

1963-64 Membership

H. A. Furlong, M.D., *Chairman*, 35 E. Johnson Avenue, Pontiac
Otto K. Engelke, M.D., 313 Washtenaw County Bldg., Ann Arbor
L. A. Drolett, M.D., 3526 W. Saginaw Street, Lansing
A. B. Gwinn, M.D., 102 E. State Street, Hastings
K. H. Johnson, M.D., 1116 Michigan National Tower, Lansing
M. R. Weed, M.D., 1059 Berkshire Road, Grosse Pte. Park
D. Bruce Wiley, M.D., 46056 Cass, Utica

Ad Hoc Committee To Study Section Representation In the House of Delegates

The 1963 House of Delegates authorized the Speaker to appoint an Ad Hoc Committee of the House to Study in depth the structure of the sections of the Michigan State Medical Society. (A resolution (#62) had been introduced resolving, in part, "That the House of Delegates authorize the election of a delegate from each of the presently authorized and established specialty sections of MSMS.")

1963-64 Membership

H. F. Falls, M.D., *Chairman*, 1313 E. Ann Street, Ann Arbor
N. L. Avery, Jr., M.D., 515 Lakeside Drive, S.E., Grand Rapids
G. S. Fisher, M.D., 1709 David Whitney Building, Detroit
G. T. McKean, M.D., 1553 Woodward Avenue, Detroit
J. R. Quinn, Jr., M.D., 2070 W. Valley Road, Bloomfield Hills
M. S. Sharp, M.D., 521 N. Capital, Lansing
P. K. Stevens, M.D., 1116 Mott Foundation Building, Flint

Committee On Certificates of Commendation

The House of Delegates Committee on "Certificates of Commendation" shall be composed of a Chairman and six members appointed by the Speaker. The Committee shall select awardees for "Certificates of Commendation" which may include both scientific and/or public service and which may be awarded annually to one or several physicians who distinguish themselves in the medical profession. The Committee shall report its recommendations to the House of Delegates.

1963-64 Membership

W. L. Brosius, M.D., *Chairman*, 1823 Fair Oak Court, Rochester
J. B. Blodgett, M.D., 76 W. Adams Street, Detroit
J. R. Brink, M.D., 50 College Ave., S.E., Grand Rapids
J. W. Rice, M.D., 421 McNeal Street, Jackson
V. P. Russell, M.D., 324 Washington Square Building, Royal Oak
H. A. Towsley, M.D., University Hospital, Ann Arbor

Committee On Constitution and Bylaws

The House of Delegates Committee to Review Constitution and Bylaws shall be composed of a Chairman and five members appointed annually by the Speaker of the House of Delegates (with the MSMS Legal Counsel acting as ex-officio member). The Committee shall periodically review the MSMS Constitution and Bylaws for possible improvements, shall study any recommendations made by component societies and individual members, and shall report its recommendations to the House of Delegates at its next Annual Session.

1963-64 Membership

H. M. Golden, M.D., *Chairman*, 218 E. Court Street, Flint
G. H. Bauer, M.D., 2015 Manchester Road, Ann Arbor
L. J. Bailey, M.D., 20905 Greenfield Road, Southfield
A. L. Brown, M.D., 35 S. Johnson, Pontiac
C. J. Pollina, M.D., 21503 Harper, St. Clair Shores
K. S. Wemmer, M.D., 1472 W. Michigan Avenue, Battle Creek

Committee On Emergency Care in Hospitals

The House of Delegates in 1962 established a Committee on Emergency Care in Hospitals and in 1963 took action to continue the Committee "so that the House of Delegates can be periodically appraised of activity in this important area."

1963-64 Membership

J. R. Pedden, M.D., *Chairman*, 445 Cherry St., S.E., Grand Rapids
Louis Carbone, M.D., 14711 Gratiot Avenue, Detroit
C. E. Darling, M.D., 673 Fisher Building, Detroit
Don Marshall, M.D., 252 E. Lovell Street, Kalamazoo

R. M. Stow, M.D., 2909 E. Grand River, East Lansing
R. G. Swanson, M.D., 314 Eastland Professional Bldg., Detroit

Committee to Study Relationships Between Doctors of Medicine and Osteopaths

The House of Delegates Committee to Study Relationship between Doctors of Medicine and Osteopaths shall be appointed by the Speaker, composed of a Chairman and eight members representative of both the House of Delegates and of The Council.

The Committee shall determine those relationships between medical and osteopathic physicians that require exploration and the methods whereby such explorations can most profitably be carried out for the public good. The Committee shall present its recommendations to the House of Delegates.

1963-64 Membership

A. B. Levant, M.D., *Chairman,* 15715 E. Warren, Detroit 24
E. G. Siegfried, M.D., 229 S. Gratiot Avenue, Mt. Clemens
C. L. Weston, M.D., Matthews Building, Owosso
E. S. Woodworth, M.D., 1200 Byron Road, Howell

Centennial Advisory Committee

The 1963 House of Delegates authorized the Speaker to appoint an Advisory Committee from the House of Delegates "to act in concert with the Committee of The Council" re the Centennial. The Council in its Annual Report, had recommended that the House of Delegates participate actively in the Centennial Celebration.

1963-64 Membership

L. F. Hayes, M.D., *Chairman,* Gaylord
Sidney Adler, M.D., 3011 W. Grand Blvd., Detroit
E. C. Baumgarten, M.D., 20867 Mack Avenue, Grosse Pte. Woods
W. C. Beets, M.D., 124 Fulton Street, E., Grand Rapids
W. C. C. Cole, Jr., M.D., 3011 W. Grand Blvd., Detroit
J. J. Lightbody, M.D., 501 David Whitney Building, Detroit

MSMS Cosponsors Event To Study Maternal Health

The Michigan State Medical Society was a cosponsor for a special conference for about 100 persons who teach expectant-parent classes.

Robert F. Trescott, M.D., Lansing, chairman of the MSMS subcommittee on lay-education for maternal health, spoke about "Education for Motherhood."

The event, at Waldenwoods, was cosponsored with the Michigan Department of Health.

Three Michigan Physicians Given Honorary Degrees

Honorary degrees were conferred on three Michigan physicians at annual commencement exercises held on Michigan campuses.

Orlen J. Johnson, M.D., of Bay City, President of the Michigan State Medical Society, was presented an Honorary Degree in the Humanities by President J. Donald Phillips, of Hillsdale College. Dr. Johnson received his bachelor of science degree from Hillsdale College in 1927.

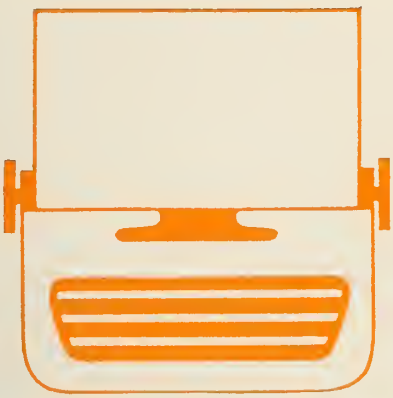
Paul Van Riper, M.D., Champion, Michigan, was granted an Honorary Degree of Doctor of Humane Letters at Northern Michigan University. The degree was conferred by NMU President Edgar L. Harden. Dr. Van Riper was honored in 1957 by the Michigan State Medical Society as "Michigan's Foremost Family Physician." He has been health officer of Champion, Humboldt and Republic Townships for more than 50 years.

E. Gifford Upjohn, M.D., Kalamazoo, was awarded the Honorary Degree of Doctor of Laws by Western Michigan University by WMU President James W. Miller. Dr. Upjohn, recently elected national chairman of the Pharmaceutical Manufacturers' Association, is a past president of the Kalamazoo Academy of Medicine.



MSMS Members Share Findings

Among the MSMS members with scientific exhibits at the 1963 Annual Session were F. J. Margolis, M.D., *(left)* and Robert Gove, M.D., both of Kalamazoo. There will be no scientific exhibits at the 1964 annual meeting, but they will be sought for the 1965 Centennial Annual Session at Cobo Hall, Detroit.



EDITORIAL VIEWS

Annual Scientific Session To Feature Panels, CPC

By Harry A. Towsley, M.D., Chairman
Annual Session Program Committee

The outstanding success of the 1963 Michigan State Medical Society Annual Scientific Session prompted the Program Committee for the 1964 session to continue with the panel discussion type program.

The wide scope of subjects presented on this program by the most competent men available in the country, representing eminent teachers in many specialty fields, should provide ample opportunity for an excellent continuing educational experience for members of the Michigan State Medical Society.

It is anticipated that there will be adequate time for discussion and questions from the floor, as well as an unusual opportunity for those present to meet and hear the outstanding medical scientists in the fields represented.

With the very able help and assistance of the many section chairmen of the State Medical Society, the following topics of current interest and areas in which many new advances have been made were chosen for the 1964 Annual Session, September 23-25 in Detroit:

Pancreatic Disorders
Shock
Maternal Deaths
Trends in Diagnosis and Treatment of Allergic Diseases
Cancer and Other Tumors of the Head and Neck
Headaches
Genesis and Sequelae of an Automobile Accident
The Recognition and Management of certain Hereditary Diseases
Skin Manifestations of Systemic Disease
Some Common Endocrine Disorders

In recognition of the excellent work by the Maternal Health Committee of the Society in reducing maternal mortality, the Program Committee was particularly desirous of stressing its accomplishments, and for this reason has arranged a clinical pathological conference, which should be of particular interest to all physicians in the practice of medicine.

It is the sincere desire of the program committee and section officers that every member of the State Medical Society take full advantage of this program.

Drug Safety Syndrome

A "drug safety uncertainty" syndrome is developing among sick people who require prescribed medication to get well or remain alive, according to William S. Apple, Executive Director of the American Pharmaceutical Association.

Dr. Apple reports that patients are asking pharmacists to assure them that the drugs which have been prescribed for them are 100 per cent "safe." This is a marked change from a few years ago when patients inquired from the pharmacist whether a drug was completely "effective."

In a sense, Americans have come to expect daily miracles from scientists, industries, and pro-

fessional practitioners in every field, particularly medicine and pharmacy.

Testifying before a congressional committee, Doctor Apple said:

"I have in my hand an unlabeled bottle containing tablets of a well-known drug. We have scores of scientific books and hundreds of scientific periodicals which contain information about the relative safety and efficacy of this drug. The experts concerned with pharmacological activities say this drug will produce gastric hemorrhage."

"One researcher reports a gastric hemorrhage after taking only two tablets of this drug. In addition to capillary damage, hemorrhages have been observed in the kidneys, brain, liver, and mucous membranes. It has been reported that one tablet of this drug may provoke a serious attack in asthma patients."

"According to the scientific literature, this drug may produce general symptoms of dizziness; deafness; perspiration; nausea; diarrhea; tachycardia. In large doses it has been observed to produce cardiac insufficiency, shock, coma, and necrosis of the liver. The drug can damage the acoustic and optic nerves to the extent of causing complete deafness and blindness."

"On March 25, 1964, one manufacturing firm marked the observance of its production of the 300 billionth tablet of this drug. What is this drug? It is acetylsalicylic acid, or aspirin. It can be legally obtained without a prescription order and without question is the most widely used drug in the world today."

One wonders how long it might have taken the Food and Drug Administration to approve a new drug application for aspirin if it had been discovered in 1964?

Aspirin is a most valuable drug because it has benefits that significantly outweigh the possible risks involved in its use. In the words of the American Pharmaceutical Association, it has a high "benefit to risk ratio." The APhA recommends that the benefit to risk ratio of a drug should be applied to the total patient universe in considering the release of any new drug and further contends that even a drug adjudged to have a negative benefit to risk ratio should be available if it will help a physician to save the life of a single patient.

Medicine and Pharmacy, the Pharmaceutical industry, and the Food and Drug Administration, have a responsibility to work incessantly and cooperatively for the most positive benefit to risk ratio.

Surely public interest in drug safety is having a good effect on governmental agencies, health professions, and drug manufacturers. Nevertheless, hysteria must be avoided, as must highly restrictive legislation which is ultimately not in the best interest of the public.

Potent Message; Thanks!

By B. M. Harris, M.D., Chairman
MSMS Publication Committee

Hats Off!

MICHIGAN MEDICINE wishes to salute nine pharmaceutical firms for an effective public educational program being carried out through cooperative advertising in some of the popular national magazines.

We especially refer to their recent advertisement, with an appealing face of an elderly gentleman with the following message:

"May good health keep me independent.

"The silent prayer forms in all our minds. That somehow we be spared the crippling infirmities of age that would make us dependent on those we love.

"Once such a prayer had little meaning. Today, miraculously, it's being answered as more and more afflictions of the aged are overcome by modern medicine. By drugs and treatments that control cardiovascular disease, clarify confused minds or enable once-hopeless arthritics to leave their beds.

"It's a satisfying job, providing for the medical needs of our aged. And as their numbers grow, the search intensifies for still better medicines to cope with these and other cruel debilities.

"To this task, many doctors and drug industry scientists are devoting their lives, spurred by the hope that the next discovery may contribute to the never-ending war against disease and suffering.

"Already, we can look forward to lives 10 years longer, on the average, than those of our parents. But more important, modern drug research is helping make these "golden years" healthy, happy ones.

"This is the value of modern drugs—protecting your health and reducing the cost of illness."

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS



PRO-BANTHINE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthine (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] "... few, if any, have seemed to offer a distinct improvement, ..."

Early investigations showed that Pro-Banthine (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthine] and propantheline [Pro-Banthine].

The name Pro-Banthine (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

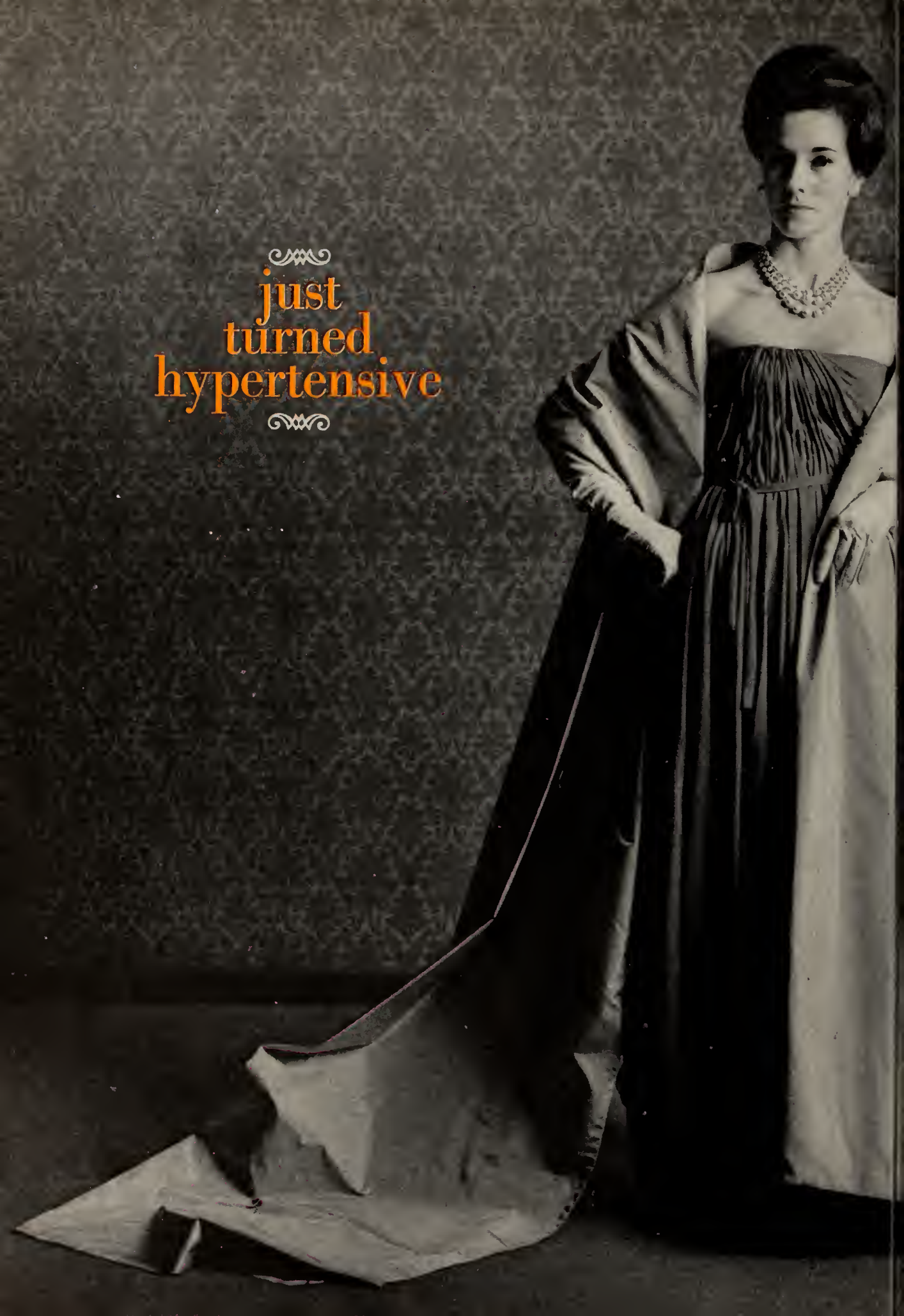
Chicago, Illinois 60680

Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

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a 15 mm. Hg. drop in diastolic pressure would also suit her very well

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HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg.,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.



1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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8278-4

✓ A Disability Insurance Check-Up

By BEN STRATTON
MSMS Insurance Consultant

Probably no one is more conscious of the need for disability insurance than you as a physician. It follows then that you have probably acquired several disability policies over a period of years.

For those who might be wondering just how good (or how bad) their disability policies are, here is a check list to help you make your own evaluation:

✓

1. What assurance do you have that the policy will not be terminated if you become a poor health risk?

If your policy states it is non-cancellable and guaranteed renewable you can rest easy. This means that the carrier cannot terminate the policy except for non-payment of premium.

If the policy states only that it is guaranteed renewable, you still have a good deal. The premium is probably less, but the company has reserved the right to raise premiums if they do so to an entire classification of their insureds.

If your policy is part of an association sponsored plan, you have the assurance that your policy will not be individually terminated. It would be necessary for the carrier to terminate the entire group, and this is usually an unlikely situation.

It should be remembered however that most health policies have a termination clause effective at a certain age. This may be 60, 65 or an even higher age.

✓

2. How well are you covered in terms of length of disability?

Most policies base this on whether the disability is due to accidental bodily injury or to illness. Because illness accounts for the greater number of claims by far, the injury provisions are generally for a longer period. A typical policy pays lifetime benefits for disability due to injury and two years if illness is the cause. The trend is to longer benefit periods and a number of companies now offer contracts that provide illness benefits all the way to age 65.

✓

3. What about the definition of total disability?

This is all important. If your policies state that you must be totally disabled from any occupation, this could result in trouble if you found that you must change to a less demanding occupation as the result of injury or disease. The broad form defines this as inability to engage in your own occupation or perhaps in any occupation for which you are fitted because of education, training and experience.

✓

4. How long must you wait before your benefits begin?

The commonly referred to "waiting period" may vary from 0 days to 6 months or even longer. This can be compared to the deductible clause on your automobile policy. If you don't need coverage from the first or 8th day, why pay for it? The premium saved could be applied to higher amounts of indemnity or to longer benefit periods. The savings are very substantial between a waiting period of 0 to 7 days and one of 30 to 90 days.

✓

5. What about house confinement?

The requirement of house confinement was quite common in the past. If your policies require that



SOCIO-ECONOMIC

you be confined indoors to qualify for benefits, you should certainly see if you cannot change these to a newer form. Often this can be done without changing carriers.

✓

6. How much monthly income do you need?

Most companies set a "participation limit" in addition to the amount they are willing to issue on one life. The monthly participation limit is often $1000 or $1200. This means that if you have $1200 monthly disability insurance and you apply to a company with a participation limit of $1000 for an additional $500 you will be declined. You probably would be accepted by another company with a higher limit however if you are otherwise insurable.

In addition, you may not insure more than 75 or 80 per cent of your income. This is understandable when you consider that disability benefits are tax free.

Each person's needs are individual. Add up the monthly expenses and payments that would continue in the event of total disability. This will give you an idea of how much of your after-tax income you should insure.

BAY COUNTY TO PAY FULL FEE

As of June, the Bay County Welfare Board is paying the full fee of the Revised Michigan Uniform Fee Schedule for Governmental Welfare Agencies.

Survey Reports on Income Of Physicians in Groups

According to a survey by the U. S. Public Health Service, the average (median) annual net income of physicians in group practice was $22,607 in 1959; the net incomes among these physicians ranged from $6,800 to $91,268. Those in the West had the highest average net incomes and those in the Northeast had the lowest.

The average stipend of residents during 1962 was $248 a month in hospitals affiliated with medical schools and $302 a month in non-affiliated hospitals. Many hospitals also provided full or partial room, board, and maintenance allowances.

SKF Foundation Gives $790,000; Much for Education

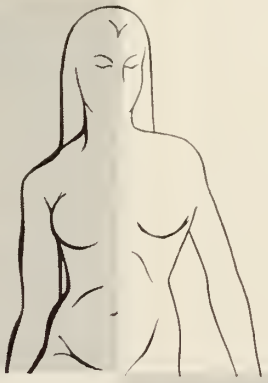
Smith Kline & French Foundation, a trust established by Smith Kline & French Laboratories, the pharmaceutical firm, gave $790,000 for scientific, educational and charitable purposes last year.

As in previous years, the Foundation's grants mainly were in the areas of medicine and the sciences related to medicine. More than half the Foundation's contributions represented support of educational activities.

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(Releasing the drug over a 6-10 hour period)

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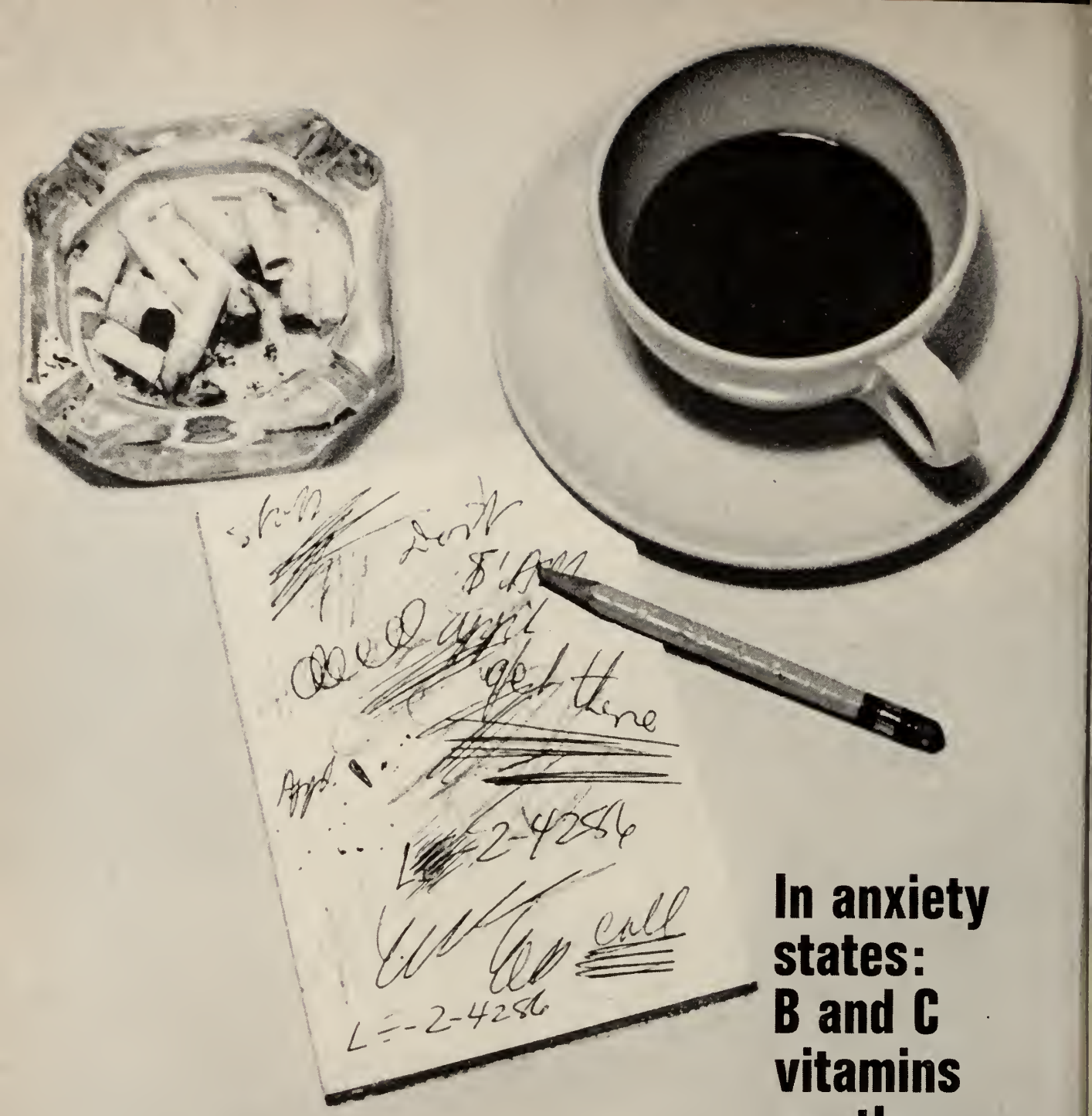
Side Effects: Rare—C.N.S.** stimulation minimal, occasionally cardiovascular and gastrointestinal reaction may be observed.
Contraindications: Severe hypertension, angina pectoris, hyperthyroidism and Raynauds disease.

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Stress formula vitamins are an important supportive measure in maintaining the nutritional status of the emotionally disturbed patient. With STRESSCAPS, B and C vitamins are present in therapeutic amounts to meet increased metabolic demands. Patients with anxiety, and many others undergoing physiologic stress, may benefit from vitamin therapy with STRESSCAPS.

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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ANCILLARY SECTION

List Winning Papers At Resident-Surgeon Day

The three residents who won awards at the Annual Resident-Surgeons Day and the Michigan Chapter of the American College of Surgeons meeting at Ann Arbor were the following:

First Prize, "Experimental Studies in Decompression Illness," presented by Myron K. Kenny, M.D., sponsored by Wayne W. Glas, M.D., Wayne County General Hospital, Eloise.

Second Prize, "Some Aspects of Wound Healing in Germ-Free Animals," presented by John Tipton, M.D., sponsored by Reed Dingman, M.D., St. Joseph Mercy Hospital, Ann Arbor.

Third Prize, "The Effects of Intra-Articular Injection of Collagenase," presented by Jack Kelley, M.D., sponsored by Louis Kivi, M.D., St. Joseph Mercy Hospital, Ann Arbor.

A total of 19 papers, representing 10 hospitals, were given.

Honored guests included J. Englebert Dunphy, M.D., Chairman of the University of Oregon Department of Surgery and President of the American College of Surgeons; and John Paul North, M.D., Executive Director of ACS.

History of MSDA Available

The history of the Michigan State Dental Association and dentistry in Michigan is now available in a book entitled "Profile of a Profession." The book, written by Robert M. Warner, tells the history of Michigan dentistry and the MSDA from their beginning to the present day. Persons interested may order it from the Wayne State University Press, Detroit 2, Mich. The book costs $7.95.

1964 Art Show Chairman Invites Early Entries

It's easy to enter the 1964 Art Exhibit at the MSMS Annual Session, September 22-25, at the Sheraton-Cadillac Hotel, Detroit.

All that interested members must do is to take their own original art work with them to Detroit for the annual session and register it with the Auxiliary Committee between 9:00 a.m. and noon, September 22.

All work must be completely original and each artist is limited to four entries which must be in one class or any combination of classes. All oil paintings must be framed and equipped with eyelets for hanging. All water colors, drawings and prints may be matted or framed, but prepared for hanging. There will be help available at the hotel, but works must be presented in person.

All usual care will be exercised in handling entries, but we cannot assume liability for accidents in handling, breakage or loss by theft. Insurance, if desired, should be carried by the exhibitor.

The exhibit will open Tuesday, September 22, at 3:00 p.m., with tea from 3:00 p.m. to 4:30.

Awards will be given in four categories:

Class I—Paintings, including oil, encaustic lacquer, polymer, et cetera.

Class II—Paintings including watercolor, casein, tempera, gouache.

Class III—Sculpture, all media.

Class IV—Ceramics.

Class V—Drawings and Graphic Art, including all print techniques.

Class VI—Three-dimensional design; weaving.

Advance registration is not necessary, but would be very helpful to the committee in planning for adequate display space. The following registration form may be placed in an envelope and mailed to the committee chairman.

I would like to enter the following in the Michigan Doctor/Wife 1964 Art Exhibit:

Name_____

Address_____

It is hoped that all doctors and their wives and friends will be sure to visit the exhibition and enjoy the talented products of Michigan doctors and their wives.

The Auxiliary chairman of the Art Show is Mrs. L. Jerome Fink, 4430 Quarton Rd., Bloomfield Hills.

U-M Medical Center Alums To Confer October 15-16-17

The University of Michigan Medical Center Alumni Society will hold its annual conference October 15, 16 and 17, with reunions for the classes ending in "4" or "9".

Also invited to return are those physicians who completed their postgraduate training at University Hospital in those same years.

The Galens Honorary Medical Society will hold its 50th anniversary reunion the same week end.

Reunioning classes will hold their own scientific programs and social events on Thursday, October 15, and Friday, October 16, will bring a full day of scientific sessions, topped by a banquet and dance. On Saturday, October 17, there will be an alumni picnic on grounds near the Michigan Stadium. The conference will close with attendance at the Michigan-Purdue football game Saturday afternoon.

John M. Sheldon, M.D., and Harry A. Towsley, M.D., will serve as co-chairmen.

The Michigan Foundation for Medical and Health Education, for the first time, has granted scholarships to two Michigan doctors to attend the Rutgers University School for Alcohol this summer. They are Victor M. Azuela, M.D., Battle Creek, and Clinton R. Good, M.D., Grand Rapids.

Three Wayne Students Cited for Research Papers

Three students of the graduating class of 1964 from Wayne State University School of Medicine won the William Beaumont Society prizes for research papers written during their four years as medical students.

Sheldon L. Spector, Detroit, wrote "Chemical Mediators involved in Passive Cutaneous Anaphylaxis in Mice," based on research done in L'hopital Broussais in France on a research fellowship.

Another winner is David E. Gross, Oak Park, who wrote "Studies on Isoenzymes of Creatine Phosphokinase Using Heat, Freezing and Electrophoresis," based on research done during the summer of 1963, under the sponsorship of John R. McDonald, M.D., Professor in the Department of Pathology and Joseph Hess, M.D., assistant professor in the medical school's Department of Medicine.

The third winner is Edward L. Applebaum, Detroit, who wrote about "Vagal Control of Cardiac Dimension." Robert S. Shepard, Ph.D., assistant profesor in the Department of Physiology and Pharmacology, sponsored his research during 1963 under a fellowship.

Wilfrid L. Hufton, M.D., is the medical director of the new Flint Community Planned Parenthood Association birth control center.

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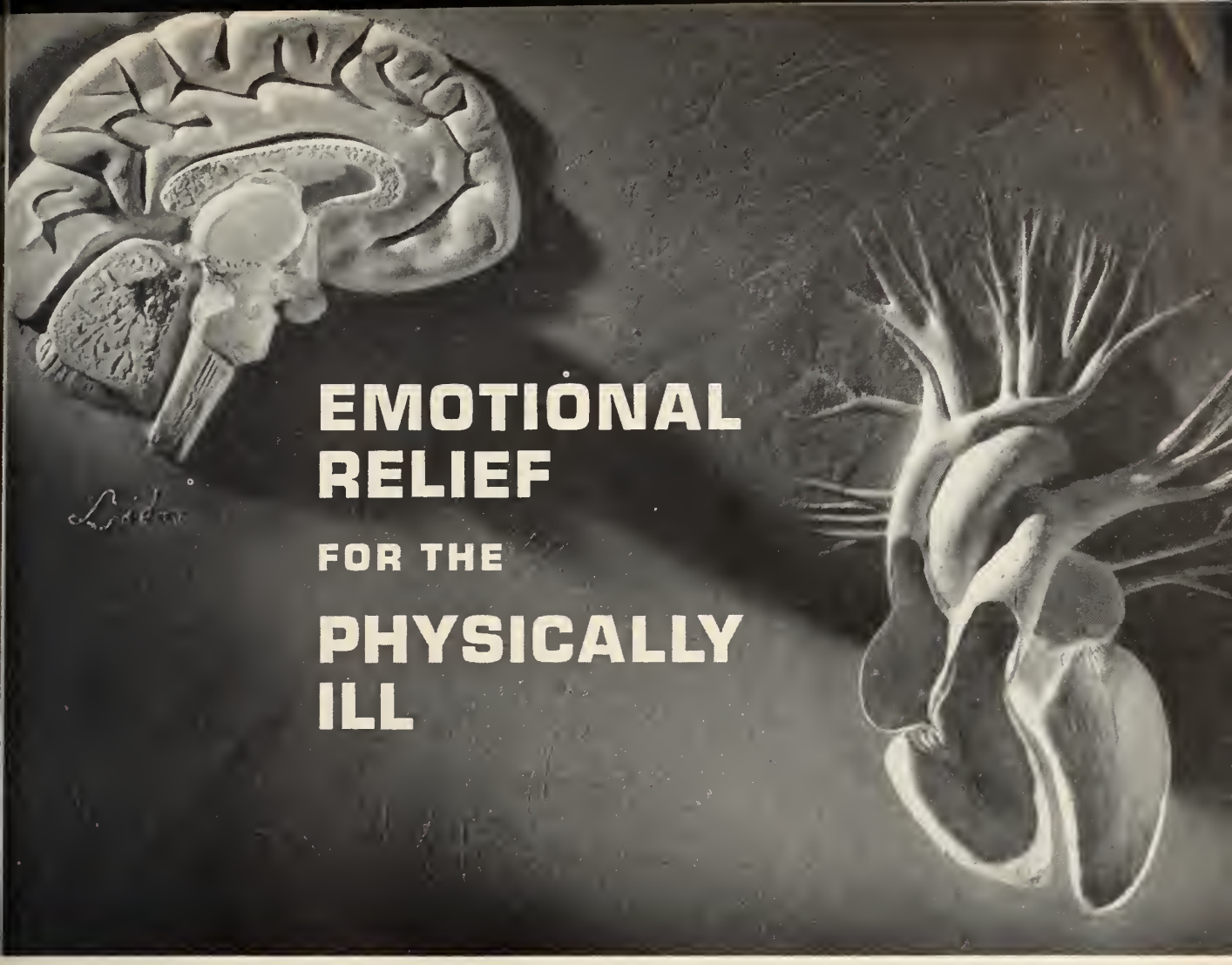
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Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

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Vision Screening



Glaucoma Detection

"Good Health for All," Theme for Pontiac Fair

By ROBERT M. BOOKMYER, M.D., President
Oakland County Medical Society

The evaluation of the "Pontiac Health Fair" has been completed by the Oakland County Medical Society. We find that the project was an appropriate activity for the county society and that it did help tell the public more about good health practices and about medical career opportunities.

The Pontiac Health Fair held May 15-16-17 was sponsored by the Professional Committee for Cooperative Community Service and by the Oakland County Medical Society. The Professional Committee for Cooperative Community Service consists of about nineteen to twenty community groups: the Michigan Heart Association, the Oakland County Pharmaceutical Association, Oakland County Department of Health, the Department of Physical Education and Athletics, Pontiac School System, Michigan Diabetes Association—to name but a few. The theme of the Fair was "Good Health for All."

The Oakland Society had the opportunity to screen all applicants for this Health Fair so that high standards for exhibits could be realized.

The Oakland County Medical Society had 1,056 square feet of exhibits, which included:

Wayne State Medical School—MD Recruitment
University of Michigan Medical School—MD Recruitment
Michigan Kidney Disease Foundation—Artificial Kidney
Michigan Health Council—Baby Emergencies
Michigan Health Council—Careers in Health
Oakland County Medical Society—Glaucoma Detection
Oakland County Medical Society—Anti-Tobacco Poster Display
American Medical Association—Poisoning in the Home
American Medical Association—Health Appraisal of the School Child
American Medical Association—Where Your Medical Dollar Goes

* * *

THE SOCIETY ALSO sponsored a poster contest, in which all the schools in the county participated, with the theme "Smoking and Health." We received approximately two hundred posters, which were exhibited throughout the school and in the exhibit hall. Our medical society gave $100 for first prize, $75 for second prize and $50 for third prize. It was a good public relations program, even apart from the Health Fair that we sponsored.

All the ophthalmologists in Oakland County contributed their time for glaucoma detection and several of the roentgenologists donated the services of their technicians for TB screening.

The county society was pleased with the success of the Fair; but they believe if they ever sponsor a



PUBLIC RELATIONS

similar project, certain situations which arose can be remedied in the future. I think it is important that the place should be centrally located and be available to the populace of the community rather than being at a location that is not convenient.

* * *

WE FEEL STRONGLY that a better date would aid in the success of any program. Perhaps, earlier in the year might be a better date, because school activities were at their height in May.

In the future, it will be essential that the school systems participate. The school child may go through and, if interested enough, may ask the family to return on another day or evening. Any future fair should not only be for several days during the week but also on the week-end, if possible.

Good press is essential. We had a public relations advisor who did an excellent job. But, again, we were up against some competition from the surrounding communities because of activities that they had planned at these dates.

It's important that we have the various civic groups and community health groups participating because without these groups a county medical society would find it very difficult to promote any Health Fair of any magnitude.

* * *

SHALL WE SPONSOR similar Health Fairs in the future? Yes, perhaps, in four or five years. The lessons that we have learned plus the lessons that Grand Rapids learned and the lessons that MSMS Health Fair in 1966 will have experienced can all help to make a fair designed to promote better health a success. In conclusion, I would like to add that it's tough not only to sell good health but also to sell a Health Fair.

Michigan Authors

James C. Moloney, M.D., Orchard Lake, "Sleeping Tiger: Do Not Disturb," *Child and Family Magazine,* January 1964.

C. J. France, M.D., and Robert Lucas, M.D., Detroit, "The Management and Prognosis of Metastatic Neoplasms of the Neck with an Unknown Primary," *The American Journal of Surgery,* November 1963.

C. J. France, M.D., C. Kouchy, M.D., K. Hergt, M.D., and O. A. Brines, M.D., Detroit, "Relationship of Histology of Prognosis in Thyroid Carcinoma," *Archives of Surgery,* April 1963.

W. A. Sodeman, Jr., M.D., and T. P. Haynie, M.D., Ann Arbor, "Hepatic Photoscanning in Hydatid Liver Cysts," *Journal American Medical Association,* April 20, 1964.

Paul Lowinger, M.D., Detroit, "Psychiatrist as a Variable in the Process of Interview and Treatment," *Nature,* March 21, 1964.

Peter A. Martin, M.D., Detroit, "Psychoanalytic Aspects of That Type of Communication Termed 'Small Talk,'" *Journal of the American Psychoanalytic Association,* Vol. XII, No. 2, April 1964.

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We undertake this support for two reasons. First, we believe society medical journals perform a very real and necessary function in publishing medical articles and society news. Second, we feel that your journal provides a good medium for our product advertising.

We are glad to have this opportunity to work with you and I would like to assure you of SK&F's continuing interest not only in the advancement of medicine as a whole, but also in your society's activities.

Sincerely,

THOMAS M. RAUCH, *Vice President*
Smith Kline & French Laboratories
Philadelphia, Pa.

•

Dear Editor:

As Legislative Chairman during the past session and now as President of the M.N.H.A., I speak for not only myself but for the 543 licensed Nursing Homes and Homes for the Aged in Michigan, which provide more than 20,000 beds for the care of the chronically ill and employ more than 8,000 people in Michigan, in thanking the Michigan State Medical Society for the aid it has given the Michigan Nursing Home Association this year.

House Bill 412, which raised the maximum Old Age Assistance grant from $90.00 to $140.00 for care in a convalescent home was passed this year only with the cooperation of all of us, who are attempting to help those older citizens who really need a helping hand. This will provide the needed increase in Old Age Assistance pensions necessary for these recipients to purchase care in hospitals and convalescent homes. This should relieve the burden of hard pressed county budgets by a total of $35.00 per month per person and should eventually lead to much needed increases in the amounts now being paid for nursing home care throughout the state by county units of government.

It is indeed unfortunate that we were not effective in getting Senate Bill 1206 passed, which would have increased the coverage in licensed nursing homes under Medical Assistance to the aged from 90 days to a proposed 180 days. It is significant that the hard work done on this bill was effective to the extent that the bill passed the state Senate 31-0 and passed the Social Aid and Welfare Committee in the House only to be lost in the Ways and Means Committee because of the midnight deadline on passage of bills, making it impossible for the committee to consider thirty to forty very worth-

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while bills which were not reported out strictly because of a time element.

The unfortunate thing is that the extension of time in licensed nursing homes, even though it apparently would cost more money initially, could save a considerable amount, since care is now being provided in more expensive institutions under MAA and the state is picking up 40% of this while the Federal government is paying for 50% of this cost.

You will be interested to know that the Michigan Commission on Aging will be organizing a committee consisting of the Michigan State Medical Society, Michigan Nursing Home Association, Michigan Department of Social Welfare, and Michigan Department of Health as well as members of the State Commission on Aging, who will be asked to study the problems of making these state formulas more equitable, so that we have a very good chance this next year of further liberalizing Kerr-Mills.

The American Nursing Home Association is also working very closely with the American Medical Association on national legislative programs. We look forward to working with you in the interest of better care for our patients for many years to come. Thanks!

Very sincerely yours,

LLOYD R. JOHNSON, *President*
Michigan Nursing Home Association

June 12, 1964

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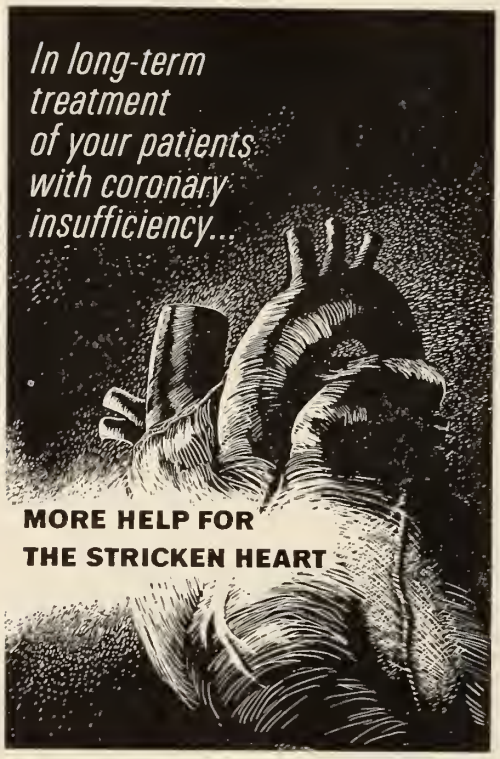
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IN MEMORIAM

FLOYD L. COVERT, M.D.

Floyd L. Covert, M.D., 84, practicing physician in Gaines for 54 years, died June 4, 1964.

A 1906 graduate of the Detroit College of Medicine and Surgery, Doctor Covert practiced in Argentine from 1906 to 1910, before moving to Gaines.

He was a Life Member of the Michigan State Medical Society.

FRANK A. GRAWN, M.D.

Frank A. Grawn, M.D., 93, of Ypsilanti, died May 31, 1964.

A graduate of Rush Medical College, Chicago, in 1896, Doctor Grawn had practiced medicine in northern Minnesota and in Michigan for 46 years. He retired from active practice in 1938 and moved to Ypsilanti in 1947.

He was a Retired Member of the Michigan State Medical Society.

HORACE W. PORTER, M.D.

Horace W. Porter, M.D., 73, Jackson radiologist since 1922 and for many years an officer of the Jackson County Medical Society, died June 16, 1964.

A graduate of the University of Michigan in 1919, Doctor Porter was secretary of the Jackson County Medical Society from 1936 to 1961 and then served as president-elect in 1961-62 and as county society president in 1962-63. He had served for many years as chairman of the Jackson Society Ethics Committee.

He was chairman of the Ethics Committee of the Michigan State Medical Society and a Former Chairman of the MSMS Cancer Control Committee.

He also served for several years as a Delegate from the Jackson County Medical Society to the MSMS House of Delegates.

Doctor Porter was a member of the American College of Radiology, Radiological Society of North America, Detroit Roentgen Ray and Radium Society and Phi Chi medical fraternity. He was a Life Member of the Michigan State Medical Society.

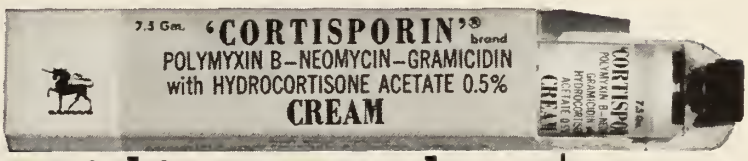
ARTHUR M. SNYDER, M.D.

Arthur M. Snyder, M.D., 51, Ferndale physician, died June 3, 1964.

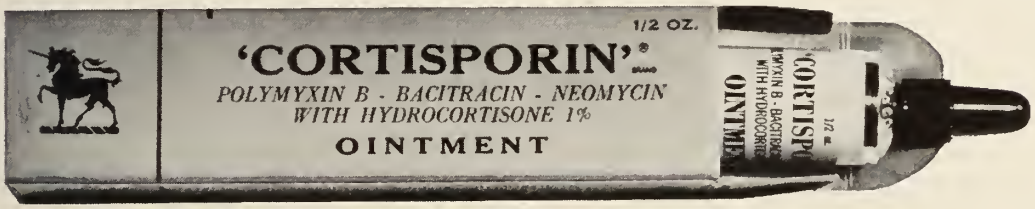
A graduate of the University of Michigan Medical School, Doctor Snyder had practiced in Ferndale for the past six years. He was a member of the American Academy of General Practice.

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New Research Center Seeks Improved Foods for Infants

By Robert A. Stewart, Ph.D.
Director, Research Center
Gerber Products Company

The new Gerber Research Center at Fremont marks a definite step toward better health through improved foods for infants. Today, food improvement means more than guaranteeing safety from bacterial spoilage or providing the essential vitamins and minerals. It also means more than eliminating contamination of pesticides and radioactive fall-out.

Today, we are concerned with the technical task of mass feeding, which is an integration of economics, consumer psychology, food technology, nutrition and medical science. Successful mass feeding will require the expert efforts of many persons trained in these disciplines.

The economic aspects of mass feeding calls for products low in price, appealing in appearance and taste, stable throughout their life on the shelf, and convenient for those using them.

Most important, improved foods must meet the nutritional requirements of the masses. These foods may have to be redesigned to meet the demands that new conditions of living place on the human body.

Nutritional knowledge is expanding with new medical knowledge. The classical deficiency diseases are extremely rare; rickets, scurvy, pellegra have become almost unknown to the general practioner. We are faced, however, with medical problems that seem to have some basis in foods. Today, we are faced with nutritional anemia in infancy, obesity in the adolescents and adulthood, cardiovascular disease and hypertension in adults, retarded mental development, and an assortment of allergic reaetions.

These are areas of mutual concern and interest to the medical profession, and those responsible for the design and sale of infant foods.

The new Gerber Research Center is dedicated to an integrated effort that reaches into all of these fields and interests.

To keep pace with the demand for more volume at lower costs, Chem Engineers and Food Technologists work hand in hand in the pilot plant on the development of continuous automated production lines which convert produce from the field to the finished product.

In the Test Kitchen, home economists develop tasty new combinations of foods balanced in flavor and dietary essentials. They also check the quality by taste tests with a panel of experts. The organoleptic quality must hold up throughout the process and in the following months of storage under varying shelf conditions.

Another laboratory is devoted entirely to the study of different types of packaging.

Agricultural research plays the important part of bringing top quality produce to the plant.

A series of laboratories are devoted to the study of the biochemical and nutritional properties of infant foods and the effect of processing procedures on these factors. These laboratories have been designed to collect data on components of infant foods of interest to medical researchers. For instance, new research has shown that mental development may be closely related to dietary intake, particularly in respect to the quality of the protein which is ingested during the early months of the infant's life. The Nutrition laboratory can survey foods for their amino acid content and determine the variation in amino acids which may result from excessive heat processing.

Gerber chemical laboratories are equipped also to provide the necessary data on these mineral components of foods as well as the trace elements of iron, copper, zinc, etc.

Improved baby foods also must take into consideration the problem of allergy which besets the infant population. With the increasing numbers of infants, we find more infants that are sensitive to various components of foods.

In the years ahead, it is obvious that there must be a close cooperation between medical research and the food industry. The new Gerber Research Center indicates Gerber's recognition of this fact and their intent to do something about it.



Among the MSMS leaders who paid tribute recently to W. S. Jones, M.D. *(center)*, of Menominee, were *(left to right)*, Otto O. Beck, M.D., Birmingham, MSMS Past President; W. H. Huron, M.D., Iron Mountain, former MSMS Councilor; D. Bruce Wiley, M.D., Utica, MSMS Secretary, and Orlen J. Johnson, M.D., Bay City, MSMS President. Plaques were presented on behalf of the MSMS Council, and the Menominee and Marinette-Florence County Medical Societies to Doctor Jones, a Past President of MSMS and Chairman of the MSMS Big Look Committee which directed the MSMS Headquarters project. Other MSMS participants on the banquet program, and not shown in this group photo, were Louis F. Hayes, M.D., Gaylord, MSMS Vice Speaker; MSMS Executive Director Hugh W. Brenneman, and MSMS Field Representative M. A. Riley.

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In systole and diastole, the human heart produces a maximum signal of only a few millivolts between two ECG limb electrodes. Mixed in with this tiny signal may be some unwanted electrical "noise", caused by power lines, nearby X-ray or diathermy machines, or even ordinary office equipment. Until now, eliminating this noise from the record usually meant time-consuming adjustments and rerunning records until the complexes were clear.

The new Sanborn 500 Viso-Cardiette now isolates such noise from the cardiac signal to an extent never before achieved — and simultaneously maintains even greater protection for the patient without the use of fragile patient fuses. The "500", in effect, sees all of the wanted ECG signal and little or no noise, to give you a diagnostically useful tracing with greater ease and speed.

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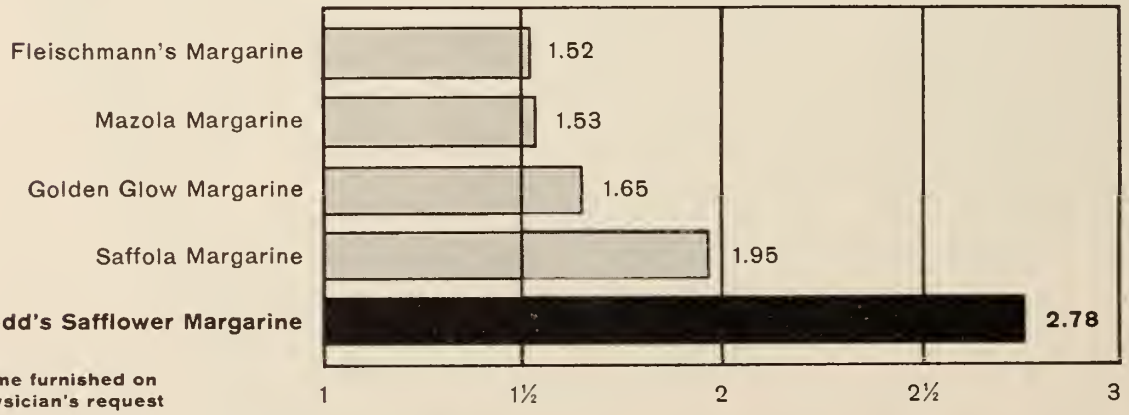


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FOR SALE, near Flint, Michigan, established practice for 39 years. Newly constructed office completely equipped and air conditioned. Five open hospitals within eight miles. Write George L. Gundry, M.D., 11736 Saginaw Street, Grand Blanc, Michigan.

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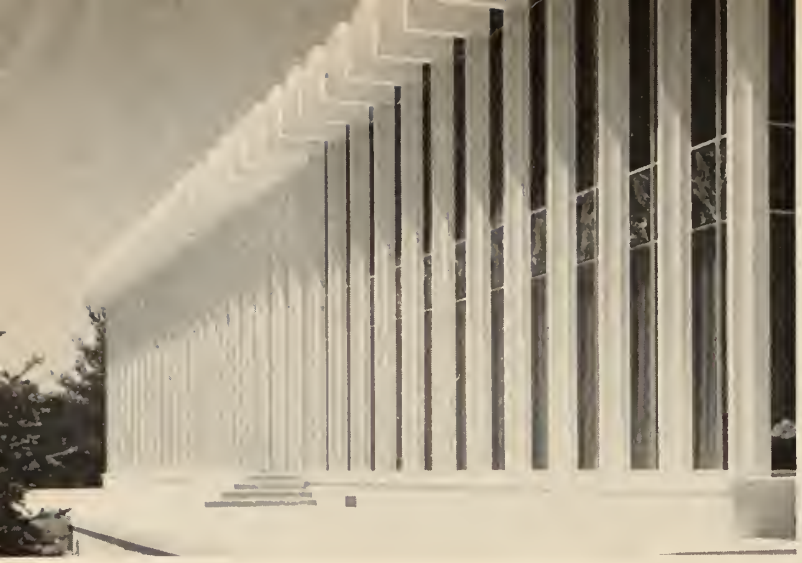
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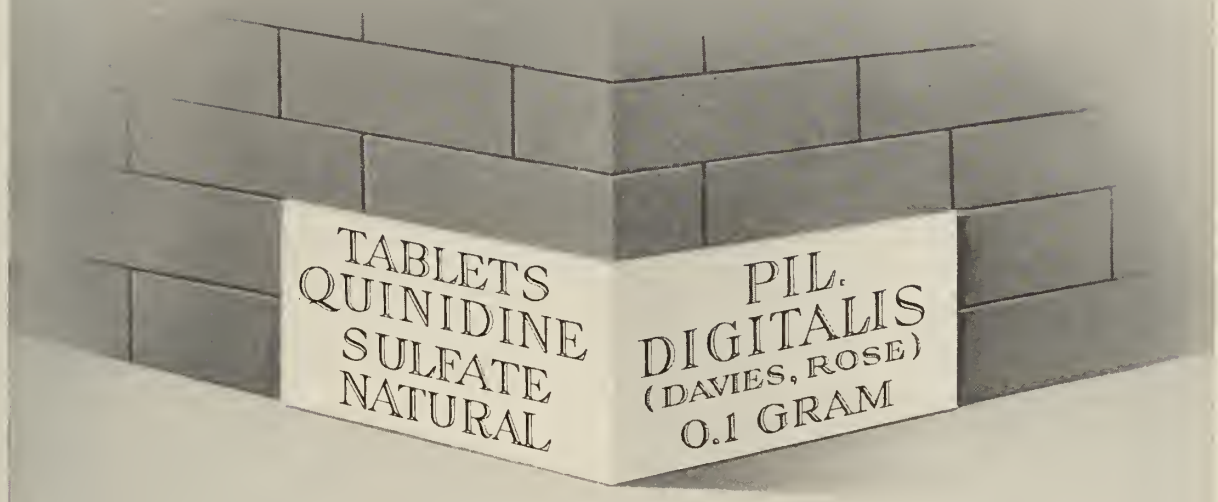
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the journal of the michigan state medical society

September 1964 • Vol. 63 • No. 9

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President's Message

Impressions of the Year

By ORLEN J. JOHNSON, M.D.
MSMS President

In penning my last President's Page the many experiences associations and meetings of the last 23 months are available. Without any desire to continue serious scrivening there are many impressions that seem worth while passing along. But the office and not the individual is paramount.

Strikingly-individual physician activity is the power of organized medical society activity. Most is from genuine interest and desire for the good of the public and the organization; with a few, personal recognition or influence. If the results are beneficial, the motivation is less important.



There is such great need for increased local medical society activity, particularly in taking the initiative in developing programs of student procurement, health education, public relations and many other areas. There are voids because some chairmen and committees do not function.

While increased society activity will help the public and the organization, it seems there can be serious consequences from the trends and unwise extension of medical care insurance. There is unwarranted criticism of increased costs under some current plans. More complete and comprehensive medical care has been requested in the automobile industry bargaining. At this time there is no knowledge as to whether it will be accepted. At present there is in force in this industry, an uncontrollable plan which is encouraging subscriber abuse. Irresponsible leadership is criticizing the medical profession for increasing utilization and costs. They now ask for a plan which, on the surface, would lead to discrediting health plans because of spiraling costs.

Michigan Medical Service sells medical services (physicians' service). There is need of control in the present plan by disease deduction, financial participation by the subscriber or other methods. Let this be done before acceding to a disastrous program—only to compete in the market place. No attempt is being made to control present abuse by the subscriber or to prevent the development of a more dangerous plan. The medical profession should take a hard look at present and future plans purveying their services.



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GENERAL INFORMATION:

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. A copy is sent to each member of the Society.

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Members are invited to submit to the Journal any suggestions for the welfare of the Society, as well as comments or criticisms of any material in the Journal. All such communications should be directed to the Publication Committee of the Journal. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted to it.

ADVICE TO AUTHORS:

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2. Submit original, double-spaced, typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.

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11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

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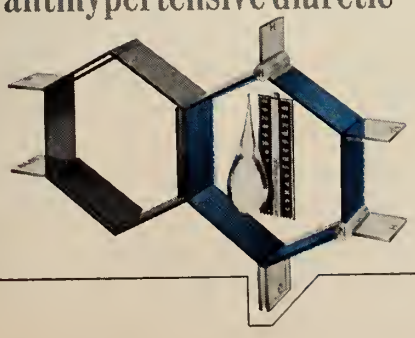
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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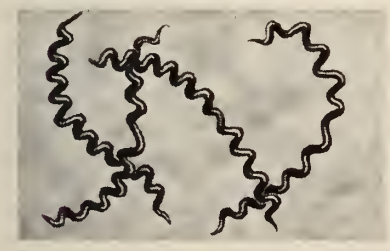
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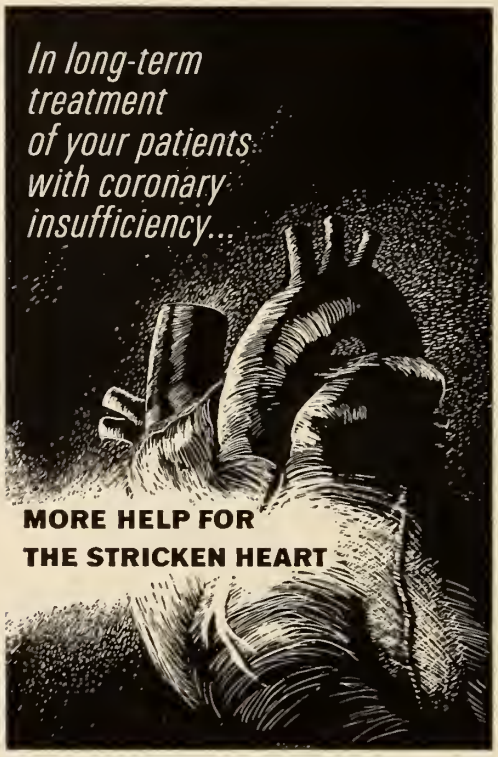
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NEWS BRIEFS

"Through his outstanding achievements in medicine, education and research, **Norman F. Miller, M.D.**, has brought honor to our state, our city and our schools," declared a plaque presented at Iron Mountain July 21 to Doctor Miller, Emeritus Professor, Obstetrics-Gynecology, University of Michigan. The Iron Mountain Rotary Club gave Doctor Miller, who was cited at the meeting also by **W. H. Huron, M.D.**, President-Elect of the Upper Peninsula Medical Society, its first "Native Son Appreciation Award."

In his 20 years of practice at Portland, **Donald Anderson, M.D.**, has permitted and encouraged each of his patients to take his rose shears and "help yourself" to roses from his 500 bushes. Recently, the *Lansing State Journal* carried a feature article about his gardening hobby.

J. L. Leach, M.D., Flint physician for 44 years, has been given the "President's Award of Meharry Medical College," Nashville, for 50 years of service to mankind. The award was made at the 1964 college commencement. In addition to providing medical leadership, Doctor Leach has been active in civic affairs, government, youth welfare and other related fields.

After a community farewell party at Mt. Morris, **A. C. Pfeifer, M.D.**, and his wife moved to Florida. He retired after more than 40 years of service at Mt. Morris in Genesee County.

The new vice medical chairman of the American Cancer Society, Michigan Division, is **Roscoe V. Stuber, M.D.**, Howell. He succeeds **Harold E. Bowman, M.D.**, Grand Rapids.

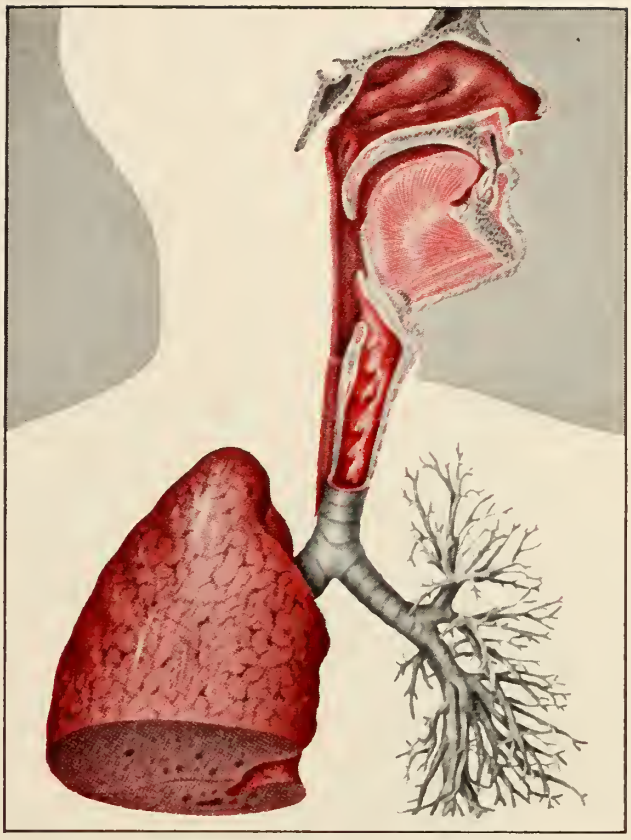
Serving as Rotary International district governor is **William J. Scully, M.D.**, Marine City. His district comprises 51 clubs in Michigan and Ontario.

One of the major summer community events at Houghton was the tribute paid by 175 to **Simon Levin, M.D.**, who has served 63 years in the Copper Country. Sponsored by the Houghton-Baraga-Keweenaw County Medical Society, the event featured a plaque presentation by **A. J. Janis, M.D.**, Hancock. **Alfred LaBine, M.D.**, Houghton, was emcee.

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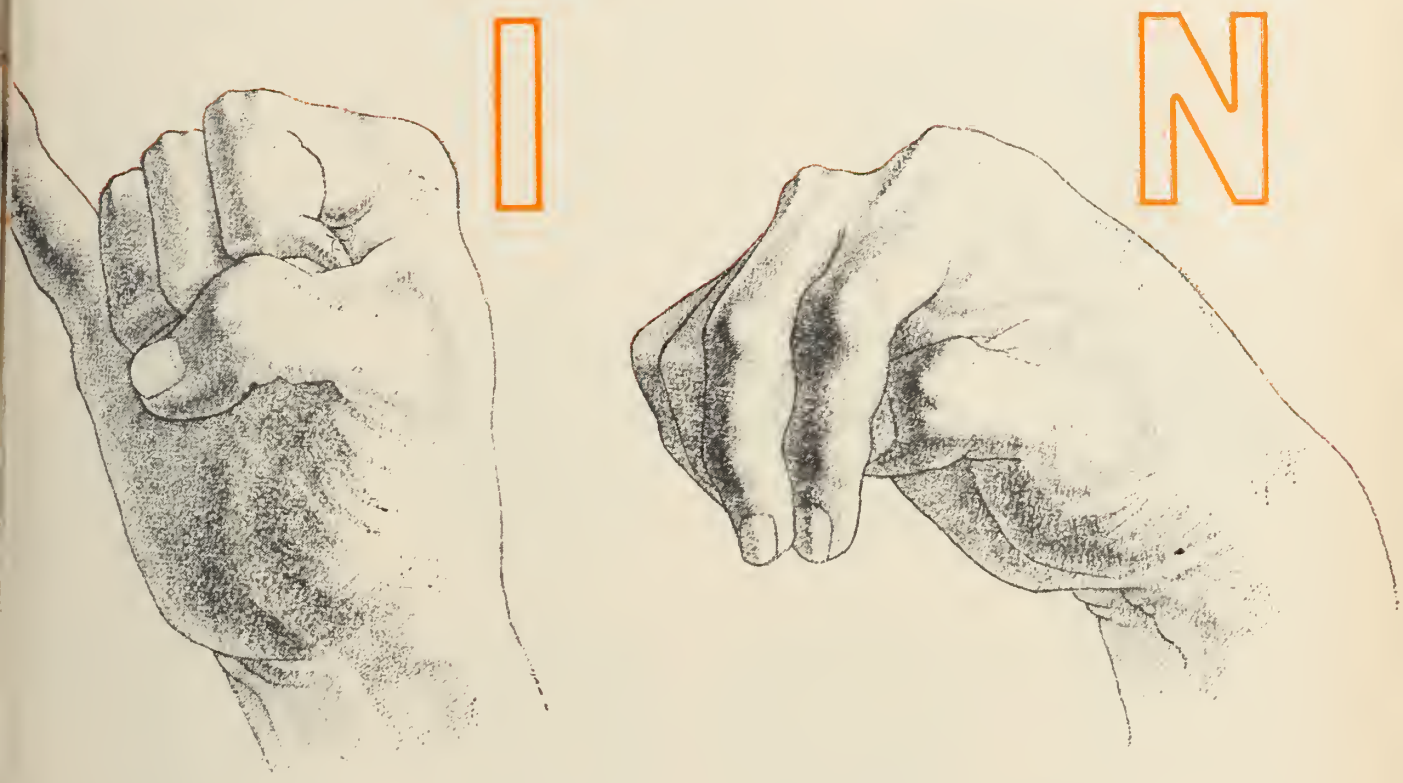
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*Cohen, et al: J.A.M.A., 165:225, 1957.

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IN MEMORIAM

FRED L. ARNER, M.D.

Fred L. Arner, MD., 80, Bellevue physician for 27 years, died July 11, 1964.

Doctor Arner was on the staffs of Leila and Community Hospitals in Battle Creek, St. Joseph Hospital, Ann Arbor, and Hayes-Green-Beach Hospital, Charlotte.

A 1911 graduate of the University of Michigan Medical School, he interned at University Hospital in Ann Arbor and practiced in Dexter and Ann Arbor before moving to Bellevue in 1937.

He was a Life Member of the Michigan State Medical Society.

T. H. COOPER, M.D.

T. H. Cooper, MD., 80, Port Huron physician and surgeon for 44 years, died June 22, 1964.

A graduate of the Illinois Medical College in 1908, Doctor Cooper practiced medicine in Portland, Oregon, for two years, before locating to Port Huron.

He was county physician and city health physician from 1912-24 and 1922-24, respectively. He was a Past President of the St. Clair County Medical Society and a Life Member of the Michigan State Medical Society.

LELAND R. KEAGLE, M.D.

Leland R. Keagle, MD., 56, Battle Creek pediatrician, died July 3, 1964.

Doctor Keagle was graduated from Northwestern University Medical School in 1934 and began practice in Battle Creek in 1936. He was Past President of the Calhoun County Medical Society, former chief of pediatrics and vice chief of staff at Battle Creek Community Hospital.

He was an Associate Member of the Michigan State Medical Society.

STARR L. KLINE, M.D.

Starr L. Kline, MD., 75, of Clark Lake, a former Detroit physician, died July 4, 1964.

A 1911 medical school graduate, Doctor Starr practiced in Detroit for 39 years before moving to Clark Lake to begin practice.

He was a Life Member of the Michigan State Medical Society.

JAMES ROBERT ROGIN, M.D.

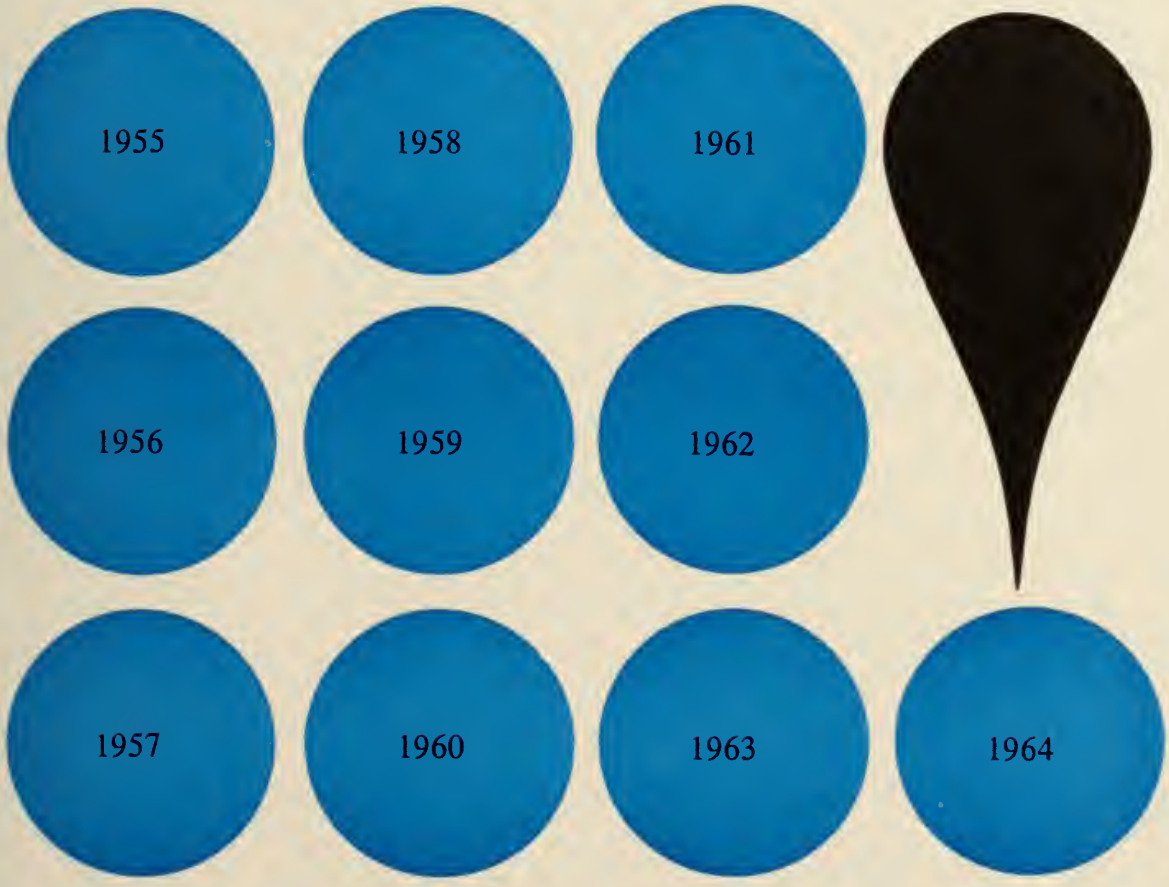
James Robert Rogin, M.D., 57, prominent Detroit dermatologist, died July 17, 1964.

A 1929 graduate of the University of Michigan Medical School, Doctor Rogin completed his residency in dermatology at Mayo Clinic, Rochester, Minnesota. He had practiced in Detroit for 29

(Continued on Page 626)

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(Continued from Page 624)

years. He was chief of the department of dermatology at Sinai Hospital and recently was named full professor by the Wayne State University College of Medicine. He was on the staff at Receiving Hospital.

Memberships included Phi Delta Epsilon medical fraternity, Detroit Dermatological Association and the Noah Worcester Medical Society.

IRVING B. SHULAK

Irving B. Shulak, MD., 59, Detroit, chief of the outpatient department of neuropsychiatry at Harper Hospital, died July 6, 1964.

Doctor Shulak was graduated in 1930 from Rush Medical College and practiced in Detroit thereafter.

He was a Fellow of the American Psychiatric Society, and a member of Central Neuropsychiatric Society and Phi Delta Epsilon medical fraternity. He was consultant in neurology and psychiatry at Herman Kiefer Hospital.

WILLIAM K. USHER

William K. Usher, MD., 55, Detroit physician and surgeon, died June 27, 1964.

A 1933 graduate of Wayne State University School of Medicine, Doctor Usher had practiced in the Detroit area for 31 years.

CALENDAR OF MICHIGAN MEDICAL EVENTS

September 20-25—Michigan State Medical Society House of Delegates and Annual Scientific Session, Sheraton-Cadillac Hotel, Detroit.

September 22-24—Woman's Auxiliary to MSMS Annual Meeting, Pick-Fort Shelby Hotel, Detroit.

September 22—Michigan Medical Service Corporation Annual Meeting, Sheraton-Cadillac Hotel, Detroit.

September 23-24—Michigan State Medical Assistants Society Annual Meeting, Statler-Hilton Hotel, Detroit.

September 22-23—Art Exhibit by Doctors and Wives—Sheraton-Cadillac Hotel, Detroit.

October 15-17—University of Michigan Medical Center Alumni Conference, Ann Arbor.

October 16—Hospital Section of Michigan Library Association, Jack Tar Hotel, Lansing.

October 21-22—Michigan Tuberculosis and Respiratory Disease Association & the Michigan Thoracic Society, Statler-Hilton Hotel, Detroit.

October 18-24—"Michigan Community Health Week."

November 5—South Western Michigan Clinic Day, Battle Creek.

November 11-12—Michigan Academy of General Practice 18th Annual Postgraduate Clinic, Sheraton-Cadillac Hotel, Detroit

November 13-16—National Society for Crippled Children & Adults, Statler-Hilton Hotel, Detroit.

November 14-15—Michigan Allergy Society, Midwest Forum on Allergy, Henry Ford Auditorium, Detroit.



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SCIENTIFIC PAPERS

Overweight Children

BY ALEX. F. ROBERTSON
GEORGE H. LOWREY, M.D.
ANN ARBOR

In 1963, the Pediatrics Department at the University of Michigan Medical Center started the Metabolism Clinic to care for overweight children. Previously, these children were referred for endocrinologic evaluation and then sent back to the family physician. It was usually suggested that the patient be placed on a diet. The children are now followed by the authors to evaluate treatment.

On the first clinic visit, a careful history and physical exam is performed and any necessary laboratory studies are done. If no other severe physical or mental illness is present and if the child and parents seem well motivated, the patient is started on a diet. This diet is carefully explained by the clinic staff which includes a dietitian and is tailored to the individual child's needs. Return visits are scheduled at approximately one month intervals. Our study includes 100 patients; 55 patients seen before the clinic began and 45 new patients seen in our clinic this last year. This article is written to describe our experience with these children and to encourage earlier diagnosis and treatment of obesity.

University of Michigan Medical School, Department of Pediatrics and Communicable Diseases.

DIAGNOSIS

Obesity is an abnormal increase in adipose tissue. In our patients, we did not measure adipose tissue directly by skin fold measurements or other means. In all cases, we plotted the height and weight on growth charts derived from the data of Reed and Stuart.[1] All children were more than two standard deviations above the mean weight for their age. The majority of the children were 30 to 50 per cent overweight and obviously obese.

In our diagnostic work-up we use the following classifications:

I. Primary obesity
II. Secondary obesity
    A. Central Nervous System disease
    B. Endocrine disease

Secondary obesity is uncommon, but important to consider in each case in order not to overlook a serious disease.

In experimental animals, appetite and satiety centers have been demonstrated in the hypothalamus. Injury to the satiety center leads to persistence of eating. Presumably, this happens in the development of severe obesity in humans with hypothalamic lesions. This mechanism seems a reasonable explanation of obesity in cases of suprasellar cysts or following encephalitis. The evidence for hypothalamic lesions is less clear in other syndromes, such as the Pickwickian syndrome, Laurence-Moon-Biedl syndrome and Frohlich's syndrome. In cases of suprasellar cysts, the patient often has growth retardation, lack of secondary sexual development and frequently, visual problems and headaches. Post-encephalitic obesity is suggested by the history and residual neurological damage. The extremely rare Pickwickian syndrome is characterized by obesity, somnolence, hypoxemia and carbon dioxide retention. The Laurence-Moon-Biedl syndrome is a complex of growth and mental retardation, lack of secondary sexual development, atypical retinitis pigmentosa, polydactyly, syndactyly and a positive family history. Frohlich's syndrome was originally described in an obese fourteen-year-old boy who had frequent headaches and later at the age of sixteen years had no secondary sexual characteristics and marked visual impairment. This diagnosis has become popular for boys who, at the age of 12 or 13, have not yet begun to develop secondary sexual characteristics and whose folds of adipose tissue obscure the genitalia. The diagnosis of Frohlich's syndrome should be reserved for cases in which there are other signs of

ABOUT THIS ARTICLE!

This study reviews the records of 100 overweight children. In none of these was a specific endocrinologic disorder found. The incidence of behavioral problems was similar in children whose weight problem began before the first birthday and in those who became overweight at 5-8 years of age. Treatment results were disappointing and the importance of early recognition and prophylaxis is stressed.

central nervous system damage such as growth retardation, visual field deficits and difficulties with temperature regulation and water balance. In our 100 patients, none of these syndromes occurred. However nine patients had mental retardation. Certainly, there are many instances of abnormal growth in retarded children but there is no definite evidence that there is a cause and effect relationship.

Endocrine disease may lead to obesity. In Cushing's syndrome, there is increased gluconeogenesis and protein breakdown. This is one of the few instances where there may be an increase in adipose tissue without an absolute increase in body weight. During the disease, there is often a slowing or cessation of linear growth. Other signs such as hirsutism, hypertension and striae may occur. If Cushing's syndrome is suspected the level of urinary 17-hydroxy steroids should be determined. Hypothyroidism is not often associated with obesity. None of our series of 100 patients showed signs of hypothyroidism, such as retardation of linear growth and bone age, skin and hair changes, or mental slowing. A protein-bound-iodine (PBI) determination should be checked if hypothyroidism seems likely.

Secondary obesity is quite rare. Several clinical points are important. If normal or slightly accelerated linear growth occurs during the development of obesity, one is less likely to find any central nervous system or endocrine disorder. The distribution of the fat over the body is not very helpful in the differential diagnosis. When secondary obesity is present, there are usually other signs more clearly pointing to central nervous system or endocrine pathology. Therefore, in our patients, when the complete physical exam is normal (except for the obesity) and linear growth has continued during the period of obesity, we classify these children as having primary obesity.

ETIOLOGY OF PRIMARY OBESITY

There is no easy explanation of the etiology of most cases of primary obesity. Its development certainly depends on ingesting more calories than are used. We shall mention a few of the more popular suggestions. Emotional disturbances are commonly seen in obese children. Forty-nine per cent of our patients had such problems, meaning that they were seeing a psychiatrist, in treatment at a child guidance clinic, or had several suggestive signs, such as frequent nightmares, severe nail biting, prolonged bed-wetting, school behavior problems, or persistent temper tantrums. In a few cases, the connection to obesity was obvious; that is, the child would increase his eating in direct response to an emotional upset. In other cases, the behavior seemed aggressive, usually involving a conflict between mother and child. In some cases, it was obvious that the parents brought the children to our clinic primarily for psychiatric help and were little concerned with the obesity. It is interesting to compare the presence of behavioral problems with the age of onset of obesity. Of 23 children whose obesity began at one year of age or under, 13 (56 per cent) had emotional problems at the first visit to our clinic. Of 25 children whose obesity began at 5 to 8 years of age, 10 (40 per cent) had psychiatric problems at the first visit. The occurrence of emotional disturbance is apparently about the same regardless of when the obesity begins. Perhaps the obesity itself contributed to the development of the emotional problem or perhaps the relationship is merely coincidental. Certainly, the relationship in the majority of cases between behavioral disorders and obesity is, as yet, unsettled.

Similarly, the influences of genetics and environment are difficult to distinguish. At present, it is impossible to say if the development of obesity is genetically influenced or merely the result of family eating patterns, depending largely upon cultural background. As in other series we found a very high percentage of obesity in other members of the family, most often in the parents, but frequently in siblings.

Inactivity has been a prominent feature in a few of our patients. In these cases, the caloric intake is excessive because the child is immobile, usually sitting in front of the television set all day. The majority of our patients seemed to have relatively normal activity but this is impossible to evaluate accurately. It is interesting to remember that a given amount of exercise requires more caloric expenditure by an obese person than by a normal one.

Occasionally, the onset of obesity may be associated with other diseases. Among our cases 14 per cent had the onset after a surgical procedure or severe infection requiring prolonged bed rest. The parents remember the operation or illness as a focal point in the child's health and this may explain the apparent relationship. On the other hand, it may be a valid relationship and caused by prolonged inactivity following the procedure.

Everyone has noticed their aesthenic friend who

eats (apparently) enormous quantities of food without gaining weight, while his wife or brother gains weight whenever a 1400 calorie diet is exceeded. Such observations lead all of us to wonder if individuals have varying "caloric efficiencies". Many of these instances are, doubtless, due to people not accurately knowing how many calories they ingest in a day and the poorly remembered snacks we all have. Others are explained by great differences in activity which are difficult to quantitate. Perhaps it is best simply to point out that all chemical reactions in the body are eventually expressed as heat and work.[2] On the basis of oxygen consumption, obese children show no evidence of any metabolic abnormality.[3] Perhaps studies carried out over longer periods of time and with more accurate techniques might show small differences not now appreciated. At present, there is no evidence to support the concept of increased "caloric efficiency" in obese patients.

TREATMENT OF OBESITY

Since February, 1963, 45 children have been seen in the clinic, their ages ranging from 4 years to 16 years. Of these, nine mentally retarded and 12 others were given no return visit due to severe psychiatric problems or lack of motivation. Twenty-four children were started on diets ranging from 900 to 1400 calories per day. Of these, 16 children have failed to return for follow up, usually after two or three visits. Five patients are being followed and are progressing well. Three patients have been discharged at a normal weight after 6 to 11 months of treatment. All but two patients lost weight on their diet in the first month of treatment. These results are not encouraging and even those few successful patients may fail to maintain a normal weight. Perhaps an explanation for the results is the length of time these children have been overweight. The majority of our patients had been overweight for 2 to 9 years before seeking or receiving medical advice. It is even more discouraging to realize that at least 44 per cent of our patients had been obese for over one-half their lives when they came to the clinic. If the problem hinges on the development of excessive eating habits, this presents a formidable period of habituation to overcome. We believe that earlier recognition and treatment is essential for better results. At least 24 (26 per cent) of our patients became overweight between 2 and 5 years of age. Pre-school children are ideal to treat since their parents still have fairly complete control over their eating. From 5 years of age until adolescence, children are fairly independent and not usually motivated to lose weight. In adolescence, the child is better motivated, but, characteristically, objects to authority. Also, by then, the eating habits are well established and hard to change. Typically healthy babies are fat at a year of age, but between 1½ and 3 years become slimmer. Unfortunately, there are no figures to tell how many overweight one-year olds will be overweight at four years of age. We do know that many children who are overweight at seven years of age will be overweight at the onset of puberty,[4] and more than 50 per cent of overweight adolescents will be so in adult life.[5] Since we know the effect of obesity on cardiovascular disease in adults we cannot, therefore, say that being overweight at seven years of age is benign. Also the emotional situation of a child who is obese upon entering school must be considered. Taking all these factors into account, we feel it is important to pay careful attention to the weight of pre-school children. At present, we would suggest that any child who is beyond the 97th percentile (or two standard deviations) in weight at two years of age be considered for treatment, unless his length is correspondingly increased. This is especially important if the parents or siblings are overweight. The prognosis of obesity in early childhood is related to the presence of obesity in the parents.[6] Therefore in children with obese parents prophylaxis is needed early. Also any child over two years of age who persistently gains weight in excess of his linear growth should be followed carefully and diet considered. With increased recognition of this problem and institution of therapy results should improve and more could be learned about this important nutritional problem.

SUMMARY

One hundred cases of obesity in children have been reviewed. The remarkable fact is that 45 per cent of these children were overweight before 6 years of age. The family incidence of obesity was high, especially in the parents. The majority of our patients were overweight for 2 to 9 years before seeking medical aid. The results of dietary treatment were poor in this group, probably due to the long habituation to overeating. Early diagnosis and treatment of overweight pre-school children is needed to avoid the chronic obesity seen in older children.

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Various methods of treatment of Ascites due to portal hypertension are briefly discussed. The rationale for performing a bilateral total adrenalectomy is outlined and a case is presented in whom this method was successful in eliminating ascites otherwise intractable.

The Role of Adrenalectomy In the Management Of Intractable Ascites

BY CLAUS P. PETERMANN, M.D.
C. JACKSON FRANCE, M.D.
RALPH R. COOPER, M.D.
DETROIT

Experimental and clinical studies in recent years have emphasized the role of the adrenal gland in the development of intractable ascites. The identification of aldosterone as the responsible agent for the marked sodium retention in this condition has led to an attack of this aspect of the problem by both medical and surgical approaches. The purpose of this article is to review recent advances in the understanding of this problem and to present an illustrative case report.

Current Concepts of the Pathogenesis of Ascites[1]

1. Portal hypertension causes weeping of the intestinal surfaces.
2. Increased pressure within the lymphatics of the liver causes weeping of the liver.
3. Decreased protein formation by the diseased liver causes lowered oncotic pressure with subsequent transudation of fluid into the abdominal cavity.
4. Increased activity of aldosterone causes retention of sodium. This was particularly investigated over the last ten years.

In 1951, Bongiovanni and Eisenmenger[2] were able to show that a high titer of "corticoid" substance was present in the urine of patients with chronic liver disease and at the same time they found a decreased amount of sodium in sweat and saliva. This pointed to a general mechanism of sodium retention.

In 1954, Leutscher and Johnson[3] observed significant sodium retaining activity in the urines of edematous patients with cardiac failure and hepatic cirrhosis.

In 1955, Lobotsky, et al[4] found that the serum of cirrhotic patients contained 25 times as much aldosterone activity as that of normal individuals. The increased amount of aldosterone can be explained by either failure of the diseased liver to inactivate aldosterone or by higher secretion of aldosterone by the adrenal glands.

Giuseffii[5] and Marson[6] found the adrenal glands to be normal microscopically in patients who had adrenalectomy in the treatment of ascites and these patients later were maintained on surprisingly low dosages of steroids. These points support the assumption that the diseased liver fails to inactivate aldosterone and consequently a higher amount of circulating aldosterone is present.

According to Truniger,[7] the sequence of events leading to the increased aldosterone level could be the following increase in hepatic venous pressure is followed by a shift of sodium and water from the intravascular compartment into the peritoneal cavity with resultant hypovolemia. This serves as a stimulus for the adrenal cortex to secrete further aldosterone. The aldosterone, however, is not inactivated by the liver giving rise to further sodium and water retention, thus completing a vicious circle.

The experimental work for doing adrenalectomy to relieve ascites was done in 1950 by Baronofsky.[8] He produced ascites in dogs by the use of tricuspid

insufficiency. Subtotal adrenalectomy relieved the ascites to a significant degree.

Similar studies were done by Davis, et al[9] in 1953. He created ascites in dogs by constriction of the vena cava above the diaphragm, then he relieved the ascites by a total adrenalectomy.

Sprafka, et al[10] in 1954 produced ascites in dogs by means of a pulmonary infundibular stenosis and tricuspid insufficiency. Development of ascites was prevented in most of these dogs by a subtotal adrenalectomy.

Hamilton[11] in 1954 used an artificial mitral stenosis in dogs to produce sodium retention and ascites. This condition was relieved in two dogs by a total adrenalectomy.

The clinical application of these experimental studies was first done by Marson[6] in 1954 in a 52-year-old male patient with ascites due to cirrhosis. His condition was greatly relieved by a bilateral total adrenalectomy. Urinary sodium excretion increased and ascites diminished. The patient had to be maintained on Cortisone 12.5 mg.-25 mg. per day in order to prevent symptoms of adrenal insufficiency. This cortisone dosage, however, was still high enough to cause slight recollection of ascitic fluid.

Giuseffi, et al[5] in 1957 described one case of a 28-year-old man with post-necrotic cirrhosis and ascites. Bilateral adrenalectomy was followed by considerable improvement. The patient was maintained on Hydrocortisone 25 mg. per day.

Baronofsky, et al[1] in 1960 treated two patients with this method, both with excellent results. A 50-year-old male with Laennec's cirrhosis and ascites underwent total adrenalectomy in 1956. No recurrence of ascites occurred over a follow-up period of two and a half years. A 36-year-old female alcoholic with cirrhosis and ascites had a total adrenalectomy in 1956. She did well for two years (maintained on Corticosone 25 mg. daily) but then resumed drinking heavily and died in hepatic coma.

OUR CASE REPORT

A 52-year-old Caucasian man was first seen in May, 1960, at which time a diagnosis of cirrhosis with wasting ascites was made. He was treated with a low sodium diet and diuretics without relief. In October, 1960, an exploratory laparotomy was done for possible porto-caval shunt revealing a pressure of 360 mm. water in the portal system. Cavernous transformation of the portal vein was encountered making porto-caval shunt impossible. A liver biopsy showed changes of active hepatitis and post-necrotic cirrhosis. Seven liters of ascitic fluid were removed during the operation. The post-operative course was uneventful, but ascites recurred within five days after the operation. His liver function remained impaired with 33 per cent BSP retention in 45 minutes, Bilirubin 1.5 mg. per cent and slightly elevated Prothrombin time of 16 seconds. Total proteins were 6.6 gm. per cent with an albumin of 3.9 gm. per cent.

After his discharge from the hospital in October, 1960, the patient resumed the medical regimen as an out-patient, but the ascites continued to be a very difficult problem producing bilateral inguinal herniae due to weakening of the abdominal wall. The hernias were repaired in April, 1961, and 22 liters of ascitic fluid were removed at surgery. Subsequently, the medical regimen was continued on an out-patient basis, but the patient rapidly recollected his ascites and gained 25 pounds within one week. On readmission in May, 1961, paracentesis yielded seven liters of fluid. The patient was treated with a 200 mg. sodium diet, Naturetin-K 5 mg. daily, and Thiomerin 2 cc. I.M. and aldactone 400 mg. daily. During a three-week period of observation on this regime, the patient gained ½ pound per day instead of gaining 3 to 4 pounds per day on an out-patient basis. This was interpreted to be a fair response to aldactone, and bilateral adrenalectomy was con-

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sidered to eliminate aldosterone and solve the problem of ascites.

The adrenalectomy was then undertaken in two stages with an interval of six days between the two operations. The patient was maintained on 200 mg. of hydrocortisone (I.M.) daily for ten days starting one day prior to the first operation until three days after the second operation. Both operations were well tolerated. Oral cortisone acetate was then substituted, the patient being maintained since on 25 mg. daily.

The urinary output after the operation was high, averaging 2800 cc/24 hours. The highest output occurred on the 9th day with 4000 cc/24 hr. A paracentesis was performed on the 7th post-operative day yielding 12 liters of ascitic fluid. Thereafter no recollection of ascites occurred. Discharged from the hospital in July 1961, the patient has had progressive improvement in general health, appetite, stamina and feeling of well being. He returned to full employment in September 1961. There has been no further evidence of ascites in the post-operative period.

SUMMARY

A brief review of the role of the adrenal gland in cirrhotic ascites has been presented. A case of complete control of intractable ascites by total adrenalectomy has been reported.

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The Term Now Is "Aging"

The AMA Committe on Aging has recommended that all segments of the medical profession, including the AMA and constituent and component societies, be urged to cease using the term "the aged" in reference to this country's older population.

In a special report, the Committee emphasized that this term, as it is frequently used to denote all persons over 65, carries undesirable and fallacious connotations. Citing Webster's Unabridged Dictionary, the Committee noted that the popularly accepted definition of "aged" was as follows:

"Old applies to one who is far advanced in years as a 'man old, wrinkled, faded, withered'."

"Aged implies extreme old age as the 'aged creature came shuffling along'."

"The implication in this term," continued the Committee's report, "is that one has reached the end point in life—that physical, social and intellectual growth is over. This implication obviously does not apply to the majority of persons over 65 today."

The Committee feels that designating the total over-65 group as "the aged" inadvertently tends to reinforce the negative image of this age period held by some segments of society and by many older individuals themselves. It has urged that the term "the aging" be used in all statements by the medical profession regarding older persons. This indicates that change and growth are still taking place.

BY JACK F. SANDERS, M.D., ALMA

A Clinical Evaluation Of Polythiazide

A fifteen-month study of Polythiazide in 135 aged domicilary patients. This study demonstrates that polythiazide (Renese) is an excellent diuretic-antihypertensive for long term use in aged patients.

The control of extracellular edema fluid (dropsy) has been a problem from the earliest days of recorded medicine. As late as the 1930's and even into the early 1940's, restriction of water intake was one of the common methods employed to reduce edema.

The acid-forming salts, particularly ammonium chloride, came into common usage during this same period. Theophylline derivatives have been used for over three decades. Mercurial diuretics were introduced in the early 1940's and occupied a prominent role in the control of extracellular fluid until the mid-1950's, and they are still used extensively; with the exception of Chlormerodrin (Neohydrin) they must be administered parenterally. The carbonic anhydrase inhibitor acetazoleamide (Diamox) was introduced in 1953; it is relatively low in sustained natriuretic action. The cation exchange resins were enthusiastically received in the mid-1950's, but they are little used now.

Since 1957 when chlorothiazide (Diuril) was introduced, we have been deluged with new and refined and more specific agents, among them, hydrochlorothiazide (Hydrodiuril, Oretic, Esidrix), methyclothiazide (Enduron), trichlormethiazide (Naqua), benzthiazide (NaClex), bendroflumethiazide (Naturetin), hydroflumethiazide (Saluron, Di-Ademol), flumethiazide (Ademol), chlorthalidone (Hygroton), and a host of combinations of drugs.

All of the thiazides are closely related and share a benzothiadiazine nucleus; chlorthalidone has a phthalimidine nucleus. A serendipitous bonus from most of these recent oral diuretics has been their anti-hypertensive effect; in fact, they are being used almost as extensively for this ability to lower blood pressure as for the control of extracellular fluid.

In our residents at the Michigan Masonic Home and Hospital at the start of this study, 136 of 280 residents required the use of a medication for the control of extracellular fluid and/or blood pressure control because of symptoms referrable to one or the other. Many agents had been employed during the previous decade. However, for one year prior to the start of this study, almost all of the patients requiring a diuretic had been maintained on chlorthalidone and a few on chlorothiazide.

The *ideal* diuretic-antihypertensive medication for any population, but more especially for a geriatric population, should have the following characteristics:

I. *Safety*
No inherent toxicity nor idiosyncratic responses.

II. *Effectiveness*
(a) Ability to promote mobilization and excretion of extracellular fluid and to maintain freedom from edema, and
(b) Ability to lower and maintain lower levels of blood pressure, particularly diastolic.

III. *Freedom from Side Effects, Subjective or Objective*
(a) Saluresis without electrolyte disturbance.
(b) Blood pressure control without hypotension or bounce.
(c) Smooth, gentle, sustained action. (To avoid subjective discomfort and dysuria, and to avoid precipitating stress incontinence in females and acute urinary re-

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Presented to the Gratiot Community Hospital Staff and to the Gratiot Community Hospital Bulletin.

tention from associated prostatism in males.)

(d) No effect on other enzyme systems, such as glucose metabolism or uric acid.

IV. *Ease of Administration*

(a) Oral administration preferable.

(b) Intermittent administration rather than daily. In an institution this size where medications are all nurse administered, a drug that is given three times weekly rather than daily affects a saving of 8-20 hours of nurse's time per week, as well as having much better patient acceptance, particularly in patients who are on several medications for chronic conditions.

This study was undertaken to determine to what degree polythiazide (Renese) measured up to these criteria for an ideal diuretic-antihypertensive.

METHOD

Out of a total population of 280, 135 domicilary residents of the Michigan Masonic Home and Hospital were studied for 15 months. Their ages ranged from 70 to 89, with a mean age of 83. The "captive population" pattern of living made it feasible and easy to observe each patient several times weekly. All of the patients had multiple chronic disease diagnoses. Forty were diabetics being controlled on tolbutamide. Almost all had mixed-type arthritis, degenerative predominating. Eight were known hyperuricemics with clinical gout intermittently.

All of them were suffering from cardio-vascular-renal disease manifested by hypertension and/or congestive heart failure with peripheral edema and pulmonary congestion. All were receiving digitalis (Digitoxin 0.1 mg. four to seven days per week.) All of the patients ate at special diet tables and were on a 1.0 Gm. salt diet throughout the study. Because of the homogeneity of the participant group and the living pattern, routines were stable with respect to activity, bed-time, meal-time, regularity of eating, type of diet, and consistency of medications. All medications were nurse administered.

All of the patients had complete physical examinations just prior to the start of the study, and laboratory studies including blood counts, urinalyses, BUN's, blood sugars and electrocardiograms. Laboratory studies were repeated at the end of each phase of the study, every six to nine weeks, and at the termination of the study. Patients were checked biweekly, or oftener if clinically indicated, for blood pressure, weight, clinical edema, rales, or subjective symptoms.

Blood pressures were obtained by nurse personnel two hours after breakfast after 15 minutes rest and were rechecked until they were stable. Blood pressures taken by the writer were consistently 10 to 15 mm. higher than the basal pressures obtained by the nurse personnel. All pressures were taken sitting; many of the patients could not stand long enough for accurate blood pressure readings.

Previous Treatment.—All of the participants had been maintained on chlorthalidone or chlorothiazide and had remained stable for at least three months with respect to blood pressure, weight, clinical edema, pulmonary rales, and subjective symptoms. The usual dose of chlorthalidone was 50 mg. Monday, Wednesday, and Friday mornings, and chlorothiazide 500 mg. on the same schedule.

Study Method.—One half of the patients were placed on 2.0 mg. of polythiazide Monday, Wednesday, and Friday mornings; and the other half were placed on chlorthalidone 50 mg. Monday, Wednesday, and Friday mornings. At the end of nine weeks, both groups were taken off medication and placed on a placebo on the same schedule for two weeks. After the placebo period, the two groups were cross switched; those receiving polythiazide before the placebo period were placed on chlorthalidone 50 mg. Monday, Wednesday, and Friday mornings, and those who had been on chlorthalidone before the placebo period were placed on polythiazide 2.0 mg. on the same schedule. These two groups were continued for nine more weeks for the third phase. At the end of the cross-switch period of nine weeks, all the participants were maintained on polythiazide for nine months, the duration of the study period.

All other medications were continued throughout all the phases of the study period of fifteen months. These included particularly digitalis (Digitoxin) and salicylates, and tolbutamide in the 40 diabetics.

Thirteen patients died during the study period, six of cerebrovascular accidents, five of chronic congestive heart failure, two of prostatism and renal failure.

RESULTS

During the first nine weeks of the study, when one half of the patients were on polythiazide 2.0 mg. three times weekly and one half were on chlorthalidone 50 mg. three times weekly, the group on polythiazide lost and maintained the loss of an average of four pounds body weight from their control level. The polythiazide group that were hypertensive reduced their blood pressures an average of 10 mm. systolic and 5 mm. diastolic (170/95 average to 160/90 average) compared to the control period; the normotensives were unaffected. The chlorthalidone group remained stable as they had in the three months control period.

During the placebo period of two weeks, both groups went rapidly out of control. The polythiazide group gained an average of eight pounds and

the chlorthalidone group an average of six pounds. One third complained of dyspnea and malaise. Almost all developed two plus or more pretibial pitting edema. One half developed wet rales at the lung bases. This phase was terminated quickly, because it was obvious that many of the patients were approaching severe clinical difficulty.

With reinstitution of diuretic therapy after the placebo period, the polythiazide and chlorthalidone groups were cross-switched. Medication was restarted on the same three times weekly schedule.

At the end of two weeks, the group now on polythiazide had lowered their blood pressures to the same levels as the polythiazide group during phase I, and the now chlorthalidone group lowered their blood pressures to the pre-study control level. The now polythiazide group lost and maintained the loss of an average of eight pounds, and the chlorthalidone group an average of six pounds. Edema and rales cleared promptly over the two week period with no severe clinical embarrassments due to the fluid retention of the placebo period. Clinically and subjectively the responses to polythiazide at this phase were the same as for chlorthalidone. Weight loss and blood pressure lowering were definitely greater with polythiazide.

Laboratory studies remained stable throughout the study period of 15 months. Sixty per cent of the patients had moderately elevated BUN's in the 22 to 38 range. There was no discernible trend in BUN's in any of the phases of the study period. Blood counts remained stable.

One fourth of the patients showed persistent albuminuria throughout the study with no discernible trend evident. There were no cases of acute urinary retention nor exacerbations of stress incontinence with either polythiazide or chlorthalidone. There were no instances of skin rash or other toxicity or intolerance to either drug. There were twelve instances of acute clinical gout with elevated uric acids during the study period, six of them immediately after the placebo period and the rest scattered during the last nine months. Eight of the instances were in the eight known hyperuricemics. They all responded quickly to oral salicylate-colchicine.



There were no clinical suggestions of hypokalemia with either drug, nor during the nine month maintenance period on polythiazide. The diabetics maintained their usual control, except during the placebo period, when all of them showed blood glucose rises, varying between 15 and 60 mg. per cent. All of the diabetics regained their previous control with no change in their diabetic program with reinstitution of diuretic.

During the nine months maintenance period on polythiazide, one sixth of the patients required either occasional supplemental increase of polythiazide dose or continued increase to 4.0 mg. on a three times weekly schedule to maintain the same clinical status. At the termination of the study, 16 per cent were requiring 4.0 mg. three times weekly for optimal maintenance.

DISCUSSION

Polythiazide in doses of 2.0 mg. three times weekly effected a further diuresis of an average of 4 pounds over the baseline level obtained by 50 mg. of chlorthalidone or chlorthiazide 500 mg. three times weekly. It also effected a lowering of both systolic and diastolic blood pressure in the hypertensives, an average of 10 mm. systolic and 5 mm. diastolic.

These observations were confirmed when the groups were cross-switched. The baseline levels had been considered to be good and adequate control prior to the study. It would appear that polythiazide in doses of 2.0 mg. three times weekly is a little more effective than 50 mg. of chlorthalidone three times weekly, as measured by fluid retention loss and blood pressure values. While the participants were considered to be at "dry weight" during the control period, it would appear that they were not and that polythiazide established a lower "dry weight" value.

Both drugs were free of overt evidences of toxicity, idiosyncrasy or intolerance during this study. However, at no time were doses of polythiazide in excess of 4.0 mg. three times weekly employed.

The twelve cases of clinical gout suggest that there is a causal relationship between polythiazide and clinical gout. Unfortunately, serum uric acids were not done routinely on all participants. However, during the same time period as the study, there were 10 cases of clinical gout in the remaining 140 residents at this facility not part of the study group, five of whom were known to have hyperuricemia with clinical gout. The fact that

six of the cases of gout occurred in relation to a diuresing period after fluid retention, raises the question as to whether there is a relationship between diuresis and the precipitation of clinical gout.

In a controlled group like this one, there is little likelihood of inducing hypokalemia with this dosage of polythiazide over a long period. The patients were maintained on a low salt (1.0 Gm.) diet, but it was adequate in protein and fresh fruits and vegetables. If the diet were not adequate or low in potassium, then it is conceivable that there might be more danger of inducing hypokalemia. R. V. Ford emphasizes the point that ". . . with the chronic use of any of these agents, the possibility of producing clinical hypokalemia should always be remembered" (Med. Clin. N. Amer., 45:961, July, 1961), even though the increase in potassium excretion is relatively slight.

Most of these participants were potential candidates for hypokalemia in that they were all digitalized patients with chronic congestive failure and liver engorgement. However, no one manifested any suggestive signs or symptoms of hypokalemia such as cardiac arrhythmias, malaise, cramps, weakness, nausea and vomiting.

There were no significant changes throughout the study period in blood counts, urinalyses, BUN's, and no trends were discernible. The diabetics did evidence decrease in glucose tolerance during the fluid retention period, but during stable periods on polythiazide and chlorthalidone they maintained good control with minimal doses of tolbutamide.

In a controlled geriatric group of patients, a three times weekly dosage schedule is adequate and well tolerated for control and maintenancy of extracellular fluid and blood pressure. The majority of such patients require only 2.0 mg. doses.

CONCLUSION

Polythiazide in doses of 2.0 mg. three times weekly controlled edema and blood pressure well for a fifteen month period in almost all of 123 aged domicilary patients. One sixth of them required supplemental doses or increase to 4.0 mg. three times weekly to maintain long term control. At this dosage level there were no evidences of toxicity, idiosyncrasy, or intolerance, and no undue side effects such as hypokalemia. Clinical gout occurred in the same ratio as in a control group not receiving diuretics. Diabetics were controlled on minimal doses of tolbutamide during long-term polythiazide therapy.

Polythiazide is an excellent diuretic-antihypertensive agent for chronic long-term management of geriatric patients.

This work was made possible by a grant from the Pfizer Company who supplied the polythiazide for the study. Without the invaluable cooperation and assistance of Anne Valkenier, my laboratory technologist, and the hard work and cooperation of the nursing personnel and the dietary department of the Michigan Masonic Hospital, the data could not have been obtained for this report.

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Dinner Dance Speaker

U. S. Congressman Gerald R. Ford, Jr., of Grand Rapids, will be the featured speaker at the 1964 Annual MSMS Dinner-Dance at Detroit, Thursday, September 24, Congressman Ford, chairman of the House Republican Conference Committee and a member of the House Appropriations Committee, represents the Fifth Congressional District.



From an experience in general practice it is apparent that cholelithiasis is not an uncommon disease in the woman thirty years of age and younger but its recognition is often delayed by failure to consider it in the young woman with abdominal pain. Data from a general hospital are given which suggest the relationship of the initial attacks of cholelithiasis in the young woman to pregnancy. Controversial viewpoints in the literature are summarized and compared. The lack of a conclusive progressive study of the development of cholelithiasis during pregnancy is noted.

Cholelithiasis In the Young Woman

BY THOMAS B. HILL, M.D.
EAST LANSING

During twelve years of general practice, I have had seven women patients ages seventeen to twenty-three undergo cholecystectomy for calculous gallbladder disease. These seven patients briefly summarized below led me to review the available literature and assemble statistical data on all cholecystectomies done at Blodgett Memorial Hospital, Grand Rapids, Michigan, in the years 1961 and 1962 to determine the incidence of cholelithiasis and cholecystectomy in the young woman and its relationship to pregnancy.

E. V. was eighteen at the time of cholecystectomy on July 11, 1952. Greenish-yellow irregular stones two to five millimeters in diameter were present. Her symptoms probably dated back to 1950 but inasmuch as she continued to have abdominal complaints postoperatively it is difficult to define accurately those symptoms secondary to cholelithiasis. She delivered her first pregnancy near term on May 15, 1952.

S. M. was seventeen at the time of cholecystectomy on June 2, 1959. Numerous small yellowish-green stones were present. Her first acute symptoms were in January, 1959. She had delivered her first pregnancy at term on November 4, 1958.

J. H. was twenty-two at the time of cholecystectomy on November 3, 1959. Many small cholesterol stones were present. Her first acute symptoms were on October 4, 1959. She had delivered her second pregnancy at term on June 6, 1959.

K. C. was seventeen at the time of her cholecystectomy on March 28, 1963. Many small greenish-yellow stones were present. Her first acute symptoms were on February 15, 1963. She had delivered her first pregnancy at term on January 29, 1963.

G. L. was twenty-three at the time of cholecystectomy on June 16, 1959. A 1.5 cm mixed cholesterol and bile pigment stone was present. Her symptoms dated back two years and were more severe the last six months. She had had no pregnancies.

A. H. was twenty-three at the time of cholecystectomy on March 30, 1963. Three 1.5 cm stones were present. Her symptoms probably dated back nine months. She had had no pregnancies.

S. O. was nineteen at the time of cholecystectomy on May 23, 1963. Innumerable finely granular yellowish-tan calculi were present. She delivered her first pregnancy at term on February 4, 1963 and her acute symptoms began about April 15, 1963.

Guttmacher and Rovinsky[1] state that the exact mechanism of formation and deposition of biliary calculi is not fully understood, but bile stasis, increased concentration of cholesterol in bile, and changes in the physicochemical nature of bile salts are all believed to play a significant part and that these three factors may operate in normal pregnancy, which may account for the fact that gallstones are much more common in parous women.

THE EXPERIENCE OF OTHERS

Gerdes and Boyden[2] reviewed the literature in 1938 in regard to the factor of the gall bladder being larger than normal and emptying sluggishly in pregnancy. They criticized the failure of

controls and pre and postpartum studies and attempted to remedy this. In 21 healthy pregnant women given gall bladder dye intravenously all but two visualized. In five cases in the first trimester, there was no significant decrease in emptying rate which averaged 73 per cent 40 minutes p.c. in the nulligravida by their technique. In 13 cases in the second and third trimester, the average emptying rate was 52 per cent, and in five of these patients checked postpartum who averaged 38 per cent in the second or third trimester, there was a return to 71 per cent six to eight weeks postpartum. These five patients also showed larger gall bladders before oral feeding to initiate emptying prepartum than postpartum. Potter's[3] statement that in 390 Cesarean sections 75 per cent of the gall bladders were noted to be large, atonic and showing globular distention is quoted frequently in the literature but is subjective and not compared to any standard.

Large, Lofstrom and Stevenson[4] did cholecystograms on 352 pregnant women, aged 13 to 43, with only 11 of them abnormal: seven definitely showing stones, one questionable and only three non-visualized. Fifty-five of these patients had postpartum cholecystograms and of two who had normal prepartum films, one had non-visualization and one had gallstones. This roughly 4 per cent of patients with newly developed disease seems more significant to me than it did to them. If two out of the next 55 of one's obstetric patients developed gall-bladder disease where none existed before, a physician should be much more actively aware of this disease as a complication of pregnancy.

The statement that there is increased concentration of cholesterol in the bile and changes in the physicochemical nature of the bile salts during pregnancy is based on Potter's[3] data from aspiration of bile from gall bladders at Cesarean sections. These data are not compared to normal values, and on reading his tabulated figures, there appears no valid basis for any such conclusion. Large, Johnston, Katsuki and Fachnie[5] aspirated bile from the gall bladders of 28 pregnant women at Cesarean section and compared it to the bile aspirated from the gall bladder of 10 non-pregnant women without biliary tract disease and found no evidence to suggest alterations in the constituents of gall-bladder bile or change in the function of the gall bladder during pregnancy which might lead to the formation of gallstones.

Peters, Heinemann, and Man[6] do demonstrate by their 145 observations on 34 normal pregnant women that after 12 weeks of pregnancy, there is a rise of variable degree in the serum lipids of every patient and that this drops in the postpartum period. The most distinctive feature is the increase in neutral fat but cholesterol and free cholesterol also consistently increase with a fairly constant ratio between them.

That acute cholecystitis requiring surgical intervention is rare in pregnancy is attested by Hamlin and his co-workers'[7] review of 26,341 pregnancies followed at Boston Lying-In Hospital where there were only four cases of acute cholecystitis (these subsided on conservative treatment) and 23 other patients with symptoms attributed to cholecystitis or cholelithiasis. Vincent[8] reviewed 136,000 deliveries at the Charity Hospital of New Orleans and found only 32 cases of jaundice and only two of these were cases of obstructive jaundice due to stones in the common duct.

Robertson and Dochat[9] made an extensive review of all reports linking gallstones and pregnancy. They quoted many series such as the following four from Germany: the first of 170 women operated on for gallstones, 52 referred their first symptoms to a pregnancy; the second of 253 women patients, 63 referred their first symptoms to a pregnancy and half of these had symptoms during their first pregnancy; in a third of 352 women, 144 related their illness to a foregoing pregnancy, and in 70 the first attack followed the first pregnancy; and a fourth of 576 women patients, 201 had their first attacks of gallstone colic noted during or shortly after pregnancy. They further analyzed these reports of 14,016 cases of women with gallstones and determined that 79.6 per cent had had children. However, they noted that of all women patients admitted to the Mayo Clinic over the age of 50, 79.25 per cent had borne children and concluded that no statistical relationship between pregnancy and gallstones exists. The dissimilarity between patient populations should be noted and is to be given further weight inasmuch as 84 per cent of 1,413 women with gallstones discovered at postmortem at Mayo Clinic had borne children.

Robertson[10] summarizes observations that must be explained by any theory of gallstone formation: gallstones occur in both men and women but more frequently and at an earlier age in women; they are formed almost exclusively during the period of active sex functions; they are almost entirely formed in the gall bladder and this may be without demonstrable anatomic changes in the gall-bladder wall; they are produced during short, not frequently repeated periods, occasionally in showers and never continuously; finally, that they are rounded when not subject to the molding influences of apposi-

tion to each other or of the gall-bladder wall. Robertson concludes that functional disturbances of the gall bladder precipitated by neurogenic factors may well be the major etiology of gallstones; in other words they are of psychosomatic origin similar to peptic ulcers. He dismisses pregnancy as an etiological agent solely on his statistical analysis in which he compares dissimilar groups; a group of patients from Mayo Clinic is not representative of the general population unless selected as below.

The age at which surgery is done for gall-bladder disease is not necessarily a good indication of the age at which the disease had its onset. The following tabular data represents the age distribution of 1356 patients operated upon for diseases of the biliary tract from 1950-53 at the Lahey Clinic (95.3 per cent of these cases had gallstones present)[11]

Age, Years	*No. of Patients*	*Age, Years*	*No. of Patients*
10-20	3	51-60	470
21-30	71	61-70	269
31-40	162	71-80	52
41-50	323	81-90	6

These data being from a well-known clinic may well be unrepresentative of an average population with only 5.5 per cent of the patients being 30 years or younger. The following data[12] from the Mayo Clinic represent only the records in 1948-49 of all permanent residents of Rochester, Minnesota, who had disease of the gall bladder as shown by x-ray evidence of gallstones or by the surgical pathology. Of 245 patients, eight (3.3 per cent) were 20 years or less in age; seven (2.9 per cent) were 21 to 25 years; and 20 (8.2 per cent) were 26 to 30 years at the time of admission for their disease; 14.4 per cent were 30 years or under with a mean age of 24 and a mean age for onset of symptoms of 18. Only four of the 15 patients 25 years or less had been pregnant. In 40 cholecystectomy patients under the age of 25 (including non-residents), only four had proven or possible evidence of hemolytic disease. By the use of data on permanent residents of Rochester only, a truer incidence of gall-bladder disease in a general population was obtained.

Gerwig and Thistlethwaite[13] describe 10 women patients under the age of 30 who were operated upon for calculous gall-bladder disease in a six-month period. In all 10 patients, symptoms began during or following a pregnancy. This series gives no indication of incidence but it does make the physician experiencing it aware of the importance of the disease in the young woman as my own experience has.

Sparkman[14] describes 100 consecutive operations on women for calculous gall-bladder disease with an age range from 20 to 85 years. Twenty-three of the operations were in women 30 years of age or under. All had completed term pregnancies; five had one child, 13 had two children and four had three or more children. Seven of the patients had symptoms during the first pregnancy or very shortly afterwards. All calculi were radiolucent, and in all but two patients, the stones appeared to consist principally of cholesterol and were roughly spherical in shape. In reviewing the literature, he concluded that the postpartum period is a time of greater susceptibility to gallstone attacks than the period of gestation itself and that the attacks of the puerperium are generally more severe than those of pregnancy. Further in his review he noted that in 176,000 pregnancies only eleven cholecystectomies were done.

At Blodgett Memorial Hospital in 1961 and 1962, a total of 481 cholecystectomies were done. There were 339 female and 142 male patients. There were 44 who were 30 years of age and under; only one was male. Three others had surgery for other than calculous gall-bladder disease. Of the remaining 40 women, 30 years of age or under, who had cholecystectomy for calculous gall-bladder disease, the following information is available:

1. Twelve of the women were 20 per cent or more above the average weight for their height and age and seven of these were over 30 per cent above the average weight.

2. Thirty-three of the women had had children. Of the remaining seven, the pregnancy history of one was not given; one was a diabetic who had already lost 150 pounds but was still 21 per cent above the average for her height and age; one had hemolytic anemia; one had a bleeding tendency that received a work-up during the admission; one was 29 per cent over the average weight for her height and weight; one was 78 per cent above; and one was 23 per cent above.

3. At least 18 of the patients had the onset of their symptoms during a pregnancy or in the first six postpartum months. In many of the charts, the data were not adequate to compare dates of onset of symptoms with dates of pregnancies.

COMMENT

Gall-bladder disease is not often enough considered in the differential diagnosis of acute pain syndromes in the young woman. Spastic or functional distress will usually be the first diagnosis considered. When sharp jabs of pain are pri-

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marily in the thorax, pleurisy will often be thought of and a chest x-ray ordered rather than a cholecystogram. Sharp, colicky pain without nausea or vomiting and with atypical location has been the presenting symptom in most of my patients. Several authors comment on the atypical presentations of symptoms in the young woman having gall-badder colic, and this may well account for the failure to make the correct diagnosis in many of these women.

The observation that the postpartum period has more frequent and more severe attacks may well be correlated with the gall bladder then having a smaller volume and also contracting to a greater degree after feeding. It seems possible that stones would be more likely moved into the cystic or common duct with more vigorous contraction.

The Blodgett series does suggest pregnancy as one of the factors in the development of gallstones in the young woman, for of the six who definitely had no pregnancies by history, four were more than 20 per cent above the average weights for their heights and ages, and one had hemolytic anemia. But contrast these data with those of the Mayo Clinic[12] where only four of the 15 patients under 25 years of age with cholelithiasis had been pregnant.

SUMMARY

Cholelithiasis is not an uncommon disease of young women. Although the present series and others are highly suggestive of a relationship to the onset of symptoms of the disease during or shortly after pregnancy, there are conflicting reports. An extension of a series of prepartum and postpartum cholecystograms, such as initiated by Large, Lofstrom and Stevenson,[4] could much better define the true incidence of cholelithiasis as a complication of pregnancy.

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To Address Delegates

Milford O. Rouse, M.D., of Dallas, Speaker of the AMA House of Delegates, will speak Sunday night, September 20 before the MSMS House of Delegates. A specialist in gastroenterology, Doctor Rouse is a graduate of the medical school at Baylor University and has practiced in Dallas since 1928. He was elected AMA Speaker first in 1963 after four years as Vice Speaker.

KNOCKING OUT POLIO

Through a Successful Mass Immunization Program (The Kent County Story)

BY WINSTON B. PROTHRO, M.D., M.P.H.
MORRIS WILDEROM, M.D.
HAROLD E. SAMUELSON, M.A., M.P.H.
GRAND RAPIDS

The successful organization and execution of a mass polio program reaching 90 per cent of the population in Grand Rapids and Kent County is now past history. How the program was organized in less than two weeks to nip a mushrooming epidemic created considerable local, state, and national interest. Through this brief summary, it is the authors' desire to share our experience in how these results were achieved.

During the latter part of August, 1963, the routine work of the Grand Rapids-Kent County Health Departments was interrupted by the successive reports of three clinically diagnosed cases of paralytic poliomyelitis among children.

Because of the threat of a potential outbreak and the possible necessity for a community-wide program, a conference was quickly called by the Health Department to meet with representatives of the Kent County Medical Society, the Grand Rapids Junior Chamber of Commerce, the Kent County Pharmaceutical Association, the Kent County Chapter of the National Foundation and consultants from the Michigan Department of Health to appraise the situation, to review the epidemiology of the cases, and agree upon a cooperative community plan for meeting the situation.

* * *

NONE OF THE cases had been immunized against polio.

Particularly alarming was the fact that the cases were located in a low socio-economic area where it was known that only about 65 per cent of the preschool population was immunized against any of the preventable diseases. Since Salk vaccine was not suitable for the apparent pressing need, it was the joint decision of the group that, subject to all cases being the same type, nothing short of a county-wide emergency polio immunization program using oral poliomyelitis vaccine would offer the protection necessary for citizens of all ages in Grand Rapids and Kent County. Blood and stool specimens submitted to the Michigan Department of Health Laboratory confirmed Type I poliomyelitis in all three cases.

In addition, five additional polio cases, later diagnosed as Type I, and several possible cases occurred by the time the program got under way. The total of eight cases totaled more than had occurred during the previous combined five year-period. No new cases have been reported since the mass program.

* * *

THE DECISION to initiate an emergency program demanded urgency in organizing for the community-wide program and the following steps were taken:

1. The executive committees of the Kent County Medical Society and the Kent County Society of Osteopathic Physicians and Surgeons were consulted to appraise them of the situation and to solicit their cooperation. Both approved the recommendation for a mass program and both received the full support of their societies.

Winston B. Prothro, M.D., M.P.H., is Public Health Director.

Morris Wilderom, M.D., is Director, Division of Disease Control and Adult Health.

Harold E. Samuelson, M.A., M.P.H., is Director, Division of Health Education and General Services.

All are members of the Grand Rapids-Kent County Health Departments.

ORAL SABIN VACCINE TYPES I, III, AND II BY AGE
KENT COUNTY MICHIGAN
(September thru December, 1963)

Round I Type I	K.O. Dav		Clinic Follow-Up		All Other Follow-Up Captive Groups		Total Immunization		July 1, 1962 Population (Provisional*)	Immunization Difference From Population
Age	No.	%	No.	%	No.	%	No.	%		
Under 1 year	7,029	2.2	472	2.9	47	0.4	7,548	2.2	9,739**	− 2,191
1- 4	34,944	10.9	1,201	7.3	159	1.4	36,304	10.4	38,805	− 2,501
5-18	108,976	34.1	3,575	21.8	1,247	10.9	113,798	32.7	105,265	+ 8,533†
19-40	90,668	28.3	4,655	28.3	5,497	48.2	100,820	29.0	104,411	− 3,591
41 and over	78,383	24.5	6,524	39.7	4,468	39.1	89,375	25.7	113,480	−24,105
All ages	320,000	100.0	16,427	100.0	11,418	100.0	347,845	100.0	371,700	−23,855
% of population	86.1%		4.4%		3.1%		93.6%		100.0%	
Round II Type III										
Under 1 year	6,898	2.2	354	3.2	34	0.4	7,286	2.2	9,739**	− 2,453
1- 4	34,830	10.9	959	8.8	141	1.5	35,930	10.6	38,805	− 2,875
5-18	109,618	34.4	2,654	24.4	838	9.1	113,110	33.4	105,265	+ 7,845†
19-40	87,380	27.4	3,817	35.1	3,984	43.0	95,181	28.1	104,411	− 9,230
41 and over	79,976	25.1	3,101	28.5	4,261	46.0	87,338	25.8	113,480	−26,142
All ages	316,702	100.0	10,885	100.0	9,258	100.0	338,845	100.1	371,700	−32,855
% of population	85.74%		2.92%		2.5%		91.2%		100.0%	
Round III Type II										
Under 1 year	6,457	2.0	160	2.7	29	0.4	6,646	2.0	9,739**	− 3,093
1- 4	34,684	11.0	620	10.6	126	1.7	35,430	10.8	38,805	− 3,375
5-18	109,260	34.7	1,425	24.3	373	4.9	111,058	33.8	105,265	+ 5,793†
19-40	86,123	27.4	2,109	36.0	3,880	51.1	92,112	28.1	104,411	−12,299
41 and over	78,220	24.9	1,547	26.4	3,181	41.9	82,948	25.3	113,480	−30,532
All ages	314,744	100.0	5,861	100.0	7,589	100.0	328,194	100.0	371,700	−43,506
% of population	84.7%		1.6%		2.0%		88.3%		100.0%	

*Age distribution based on census, arithmetic progression, births, deaths, and school enrollment. Total population is supplied by the Michigan Department of Health.

**Includes infants under two months of age. Vaccine was *not* given to infants under two months of age.

†Represents an unknown percentage of error in tallying procedure, error of not more than 1 per cent growth between 1962 and 1963 age estimate based on Sept., 1963, school membership of 106,549, and an unknown percentage of non-residents participating in program.

2. The United States Public Health Service Communicable Disease Center in Atlanta, Georgia, was consulted and declared that the situation met the criteria for an emergency-type program. The Public Health Service agreed to furnish Type I vaccine for all children under 18 years of age and sent two educators and a physician to assist in developing the local program.

3. Local organizations thought to be interested in assisting the Grand Rapids-Kent County Health Departments in the program were contacted. The following groups agreed to assist actively and to serve as cosponsors of the project:

- The Grand Rapids Junior Chamber of Commerce
- The Kent County Chapter of the National Foundation
- The Grand Rapids District Nurses Association
- The Kent County Pharmaceutical Association
- The Kent County Medical Society
- The Kent County Society of Osteopathic Physicians and Surgeons

The Health Department called the first planning meeting on September 11 and each of the sponsoring groups was asked to send a representative. At this meeting, the City-County Health Officer explained the circumstances resulting in his declaration of a medical emergency and the effort necessary to stop the pending epidemic and to prevent another outbreak of this type from ever occurring. A steering committee was formed consisting of representatives of each of the sponsoring groups. Detailed plans were developed for implementing the program and Saturday, September 21, was chosen as the day for the first round with Rounds 2 and 3 to be conducted on November 2 and December 7.

* * *

THE TERM, "K.O. Polio," was adopted as the identifying name for the project. It was decided that Type I polio vaccine would be offered first, followed by Type III and Type II. The 68 carefully selected station sites suggested by the Health Department were adopted by the steering committee.

Realizing the importance of an informed citizenry, the steering committee met with representatives of the press, radio and television September 12 to appraise them of the situation and to solicit their help in carrying the story to the public.

The steering committee met several times before the day of the first program to work out the following specific details to implement the program:

I. *Duties Accepted by Each Sponsoring Group*

1. *Grand Rapids-Kent County Health Departments.*—Responsible for coordination and leadership in the development, promotion, and execu-

tion of the total program, policy decisions and basic planning.

2. *Grand Rapids Junior Chamber of Commerce* (including the Jaycee organizations from Rockford, Lowell, Wyoming, Grandville and Walker).—Responsible for the procurement and training for team captains at each center, procuring of clinic centers, ordering all vaccine, distribution, packaging and storage of frozen vaccine and station supplies, station organization and basic planning.

3. *Kent County Chapter of the National Foundation.*—Responsible for financing the project, the collection of all contributions, procurement and organization of non-professional volunteers at the station sites and basic planning.

4. *Kent County Medical Society.*—Responsible for procurement and orientation of physicians for duty at station sites, assistance with medical policies and basic planning.

5. *Kent County Society of Osteopathic Physicians and Surgeons.*—Responsible for the procurement and orientation of physicians for duty at station sites, assistance with medical policies and basic planning.

6. *Grand Rapids District Nurses Association.*—Responsible for procurement and orientation of all nurses for duty at station sites.

7. *Kent County Pharmaceutical Association.*—Responsible for the procurement and training of all pharmacists for duty at station sites.

II. *Selection of a Headquarters Location on the Day of the Program*

The local wholesale drug house through which the purchased vaccine was secured volunteered their facilities and offices as the headquarters on the day of each program.

III. *Operation at Station Sites*

Every effort was made to utilize schools as station sites based on the assumption that it would be the most practical place to attract family units outside of the home. Some centers were established in shopping areas to accommodate those not having close association with schools. Saturday was selected as the day most likely to attract entire families. With the exception of six half-day stations in sparsely populated areas, each program was open from 9 A.M. to 6 P.M. Stations were closer together in the low socio-economic area to minimize the distance anyone would have to travel.

Population was analyzed in and around each of the 68 selected program sites. Every effort was made to predetermine the amount of traffic expected and to organize each station with one, two or three feeding lines to minimize congestion and confusion.

Orientation meetings were held for pharmacists and team captains and the duties of physicians, team captains, pharmacists and nurses were prepared in printed form for each participant.

Vaccine for each of the three rounds was ordered in the amount of 20 per cent over the actual population of the county. Vaccine was distributed to the centers in insulated cartons with dry ice. The amount of vaccine distributed to each center was based on area population for the first round. This proved to be unsatisfactory because of the amount of transferring of vaccine from one site to another during the first round. The final two rounds of the program utilized the experience of the first round to determine distribution amounts and greatly reduced the redistribution problem.

IV. *Promotion.*

A very intensive community promotion program was carried out under the leadership of the Health Department. All radio, television, weekly and daily newspapers throughout the county contributed vast amounts of free time and large blocks of free space in the form of public service announcements. Churches, schools, industries, unions, hospitals, department stores, gasoline stations, dairies, pharmacies, theatres, bowling alleys, barber shops, beauty salons, bakeries, public centers, preschool nurseries, drug and grocery wholesalers, linen companies, laundries, and other public places where people congregate assisted in distributing either literature, posters or made public service announcements over loud speaker systems or by word of mouth.

Boy Scouts and Youth Council of the National Association for the Advancement of Colored People assisted in house to house distribution of literature in specific sections of the city and county.

Two local amateur radio groups assisted with communications on the day of the program. The Kent County Emergency Radio Group (ham operators) established their radio headquarters in the distribution center on the day of the program. This group was responsible for radio contact with groups of drivers and volunteers who assisted in distributing vaccines and supplies to the various stations. The Grand Valley II Meter Group, who are unlicensed radio operators, maintained contact with volunteer drivers who personally delivered vaccine to individuals not having transportation or who were otherwise shut in.

V. *Make-up Clinics*

Five make-up clinics were held following Round 1 and six make-up clinics were established for Rounds 2 and 3. The make-up clinics were carefully established in convenient centers of the city and county and were held within one week of each of the original distribution days.

Vaccine was also delivered to various hospitals and other institutions the Monday following each program. This procedure enabled the use of thawed vaccine that otherwise might not have been used. The attached statistical report will attest to the excellent community cooperation and acceptance of the program.

Explains State Lab Virus Testing Services

By Michigan Department of Health

LANSING—With the advent of the antibiotic era, it is recognized that bacterial diseases are declining as a major health problem and viral diseases are becoming relatively more important. As our knowledge of the variety of diseases caused by viruses grows, it becomes increasingly important to relate our clinical diagnosis to known etiologic agents.

For example, the diagnosis of "non-paralytic polio" has given way to "aseptic meningitis" with the increased recognition that the clinical syndrome may be caused by a variety of viral agents, including familiar ones such as mumps and herpes simplex. Frequently laboratory studies are the only method of determining the virus causing a given patient's illness.

The list of viral diseases of 25 years ago was mainly composed of diseases distinguished on a clinical basis, such as smallpox, chickenpox, rubeola, rubella, and yellow fever. As knowledge and techniques in the field of virology improved, it soon became apparent that some of the clinical diseases were actually caused by a variety of viruses, for example, "non-paralytic poliomyelitis."

* * *

ON THE OTHER HAND, some viruses can cause a variety of clinical syndromes. For example, in a single epidemic, Coxsackie B-4 caused pleurodynia, herpangina, abdominal pain, orchitis, aseptic meningitis, and myocarditis.[1] Several agents have been implicated as the cause of acute exanthems, many of which are difficult to distinguish from the classical acute exanthems. Some viral agents have been associated with seemingly new and distinct syndromes, such as "Hand-Foot-and-Mouth Disease" caused by Coxsackie A-16.[2]

Attempts to diagnose viral illnesses can raise some interesting problems. Recently, a child had the onset of aseptic meningitis shortly after receiving attenuated oral polio vaccine. As expected, polio virus was found in his feces and he displayed a rise in serum antibody titer. However, he also had a significant rise in antibodies to mumps—a frequent cause of this syndrome. Which of his concurrent infections caused his illness, attenuated poliovirus or mumps?

* * *

DETERMINING that a given viral agent is the cause of a given disease is often difficult. The mere presence of a virus in the body fluids or excreta of an ill person does not necessarily mean that the disease is caused by that agent. Subclinical virus infections are common and many viruses persist in the body for considerable periods after infection. If, on the other hand, a serum antibody rise is detected during the course of the illness against the agent isolated, the temporal relationship between the infection and the disease is established and makes the association between the two much stronger. If a given virus is associated with an illness repeatedly, either in many isolated patients or in an epidemic, the casual relationship becomes accepted.

Some viruses are difficult to isolate in the laboratory. For these, we often have to depend upon a rising serologic titer to incriminate a specific virus. This is useful if the disease in question and the virus have clearly been shown to be associated. If they have not been clearly associated, the use of serology alone may be misleading, particularly in individual patients.

* * *

THE DIVISION of Laboratories performs diagnostic tests for most of the common virus diseases. A list of these services is available from the Michigan Department of Health. This service allows the physicians of Michigan to make first-hand observations on the relationship between some of the illnesses they see in practice and the virus agents for which we can test. As knowledge and techniques develop in virology it is extremely important to obtain the clinical information that is necessary to make the virus laboratory work meaningful. It is vital that meaningful specimens be submitted for virus diagnosis. A blood specimen sent in for "viral studies," as is occasionally done, cannot be processed. The cost in time and money for such a "hunting expedition" of questionable significance is prohibitive.

On the other hand, an investigation into probable etiologic agents can be started promptly on proper specimens. Only through repeated observations and viral studies of individual patients and epidemics of seemingly related illnesses will we be able to bring order to the complex and varied data that now exists about the etiology, diagnosis, and epidemiology of virus diseases.

References

1. Artenstein, Cadigan, Jr., Epidemic Coxsackie virus infection with mixed clinical manifestations. *Ann Int Med*, 60:196 (Feb.) 1964.
2. Alsop, Flewett and Foster: Hand-foot-and-mouth disease in Birmingham in 1959. *Brit Med J*, 1708 (Dec. 10) 1960.

Cards, Brochures Offered MSMS Members

Urge Use of Emergency Identification Cards

Every MSMS member is urged to join in a statewide effort to provide an emergency medical identification card to all patients who need special care in emergencies.

A mailing by MSMS in August introduced the project to the members and a return postal card permits members to order copies of the standardized AMA-MSMS card to distribute to their patients.

MSMS is making not only the cards available to members, but also supplies of an AMA educational folder for distribution in the doctor's office. The folders will help explain the new symbol to the general public.

* * *

DOCTORS, WHO HAVE not as yet returned the order blank, are urged to write MSMS, Box 152, East Lansing, for a supply of cards and brochures.

This MSMS project is the outgrowth of a resolution adopted by the MSMS House of Delegates and implemented by the MSMS Public Relations Committee and The Council.

The back-to-school, fall season appears to be a "natural" time for such a project.

The AMA-MSMS card is intended to supplement rather than replace the identifying medallions presently distributed by various organizations and agencies. A list of firms that manufacture medallions also has been sent to MSMS members. Doctors may use their own discretion in recommending any medallion-type device or manufacturer.

* * *

ACCEPTANCE OF THE six-sided, stop-sign symbol adopted by the AMA in 1963 has been universal. Many state and national medical and health organizations are joining the move to obtain maximum use of the cards. The symbol indicates to all who see it that the wearer suffers from a chronic disease or has violent allergy reactions to various medications.

MSMS hopes that every member will join in promoting the symbol as the universal indicator of the presence of emergency medical identification. The MSMS project is two-fold: To urge doctors to give cards to their patients needing them, and to help the public recognize the meaning of the symbol.

MD-PAC Seeking To Show Film

MD-PAC members, in an effort to interest more physicians in political activity, are scheduling a new AMPAC film at many of the county medical society meetings for this fall.

"How the Opinion Maker Makes Opinion in Politics" is the title for the 30-minute, 16 mm film, which is available from MD-PAC, Box 169, East Lansing.

The film suggests three steps to effective political opinion making: (1) Knowing what you are going to say, (2) Say it, and (3) Keep aware of the many opportunities within your daily route of expressing your opinion.

Grants Aid Medical TV

Several grants for medical television were received by the University of Michigan Regents at their last meeting.

A grant of $50,000 was received from the Herbert H. and Grace A. Dow Foundation, of Midland, for the Medical School Color Television Fund.

A gift of $15,000 was received from the National Fund for Medical Education to establish a program of Television Tapes for medical education.

* * *

DETROIT—The International Symposium on Pain will be held at the Henry Ford Hospital, Detroit, October 21-22-23. Interested doctors may obtain information from Robert S. Knighton, M.D., 2799 West Grand Boulevard, Detroit.

MCCC Rules Changed On Tonsillectomies

The Michigan Crippled Children Commission announces it is no longer routinely requesting a second opinion before authorizing tonsillectomies for children covered by its program.

The Commission will authorize a physician to do a tonsillectomy who has the approval of the credentials committee of his hospital to perform this procedure.

As in all cases of elective surgery, physicians should request prior approval before doing a T&A when the Commission is expected to participate in payment of the medical and/or hospital costs for this procedure.

* * *

ANN ARBOR—One of the series of 19 postgraduate courses offered by the American College of Physicians will be held in Ann Arbor, November 16-20. A course in "Fundamental Concepts of Gastroenterology" will be taught at the University of Michigan, with H. M. Pollard, M.D., as the director. Information may be obtained from the ACP, 4200 Pine Street, Philadelphia.

Here's the Latest News

Once again, these four colored pages carry late-breaking news as an added service of Michigan Medicine to the members. A late deadline permits Michigan Medicine to insert these four pages as the journal is being assembled.

COMMUNITY HEALTH WEEK, OCT. 18-24 IN MICHIGAN



Community Health Week, to be observed in Michigan and the Nation during October 18-24, provides an opportunity for each physician to join in an important public-service project.

The purpose of Community Health Week is to inform the public of the dramatic advances in modern medical science during the past few decades and to encourage citizens to cooperate with the medical profession in promoting good health.

Michigan's state-wide program for Community Health Week was acclaimed best in the Nation in 1963 by the American Medical Association.

The Michigan State Medical Society has again asked the Michigan Health Council and the Michigan Association of the Professions to augment its efforts in sponsoring and implementing the Nationwide Community Health Week program of the American Medical Association.

County Society Presidents are urged to immediately appoint a Community Health Week Chairman and committee to carry out the week-long program. The Community Health Week kit of materials will be sent to each county society in the near future.

The opportunity afforded during Community Health Week is unlimited in increasing citizens health knowledge. The Medical and Allied Health professions have an excellent week-long opportunity to enhance its prestige and public image during Community Health Week.

Makes Long-Distance Speech

A telephone call from Ann Arbor to Traverse City "stole" the show at the 1964 Coller-Penberthy Medical Conference.

All the outstanding medical authorities from Michigan and other states performed well—but the physicians went home surely remembering also the phone call.

The call—amplified over a PA system—was a feature of the closing banquet on July 31. Unable to attend the Conference for the first time since it started 44 years ago, Frederick A. Coller, M.D., was confined to his home due to illness—but he was able to extend his wishes and visit with the men through the special telephone hookup. One of the honored guests at the banquet was Edwin L. Thirlby, M.D., Traverse City, co-organizer of the medical conference.

Attendance this year increased another 10 per cent with 313 total registrants. General Chairman Frank H. Power, M.D., reports that 254 doctors were registered—and that the final banquet reached a new attendance mark of 279.

Open to all physicians, the 1965 Conference will be held again the last Thursday and Friday in July.

WE GET LETTERS—

Congratulations on the new "Medigram" newsletter. It is concise and well written; should command wide readership.

LEO E. BROWN
Assistant to Executive Vice President, AMA

I like the "new look" of the new MICHIGAN MEDICINE. "Medigram" also is a fine addition to your communications. Please extend my congratulations to all concerned.

JIM REED, *Director*
AMA Communications Division

H. A. Towsley to Lead American Academy Of Pediatrics

H. A. Towsley, M.D., Ann Arbor, will be installed as President of the American Academy of Pediatrics at its annual meeting October 24-29 in New York City. A member of the executive board and chairman of the Michigan-Indiana - Ohio - Ontario District since 1960, he was appointed President-Elect of the Academy recently following the death of Harold F. Flanagan, M.D., who had been elected to that post a year ago.



Program chairman for the 1964 MSMS Annual Scientific Session and long active in MSMS affairs, Doctor Towsley was chairman of the Michigan chapter of the Pediatrics Academy from 1952 to 1958.

Cornell Crash Study Director Salutes MSMS

The Director of the Automobile Crash Injury Research program at Cornell University writes: "It is with a deep sense of appreciation that we salute the members of the Michigan State Medical Society who, as a supplement to efforts directed toward accident prevention on our highways, are making an important contribution in our study toward the injury prevention approach in this vital area of traffic safety."

That praise by ACIR followed recent action by the *Medical Tribune* in presenting the "Lifesaving Achievement in the Service of Health" to the Cornell project.

At present, MSMS members in the 26 counties in the northern portion of the lower peninsula are filing accident-injury reports again. It was five years ago when MSMS participated in the first phase of the study, and other sections of the state will join soon in this follow-up check.

* * *

DETROIT—The Detroit Psychoanalytic Society will hear Henry Krystal, M.D., and Herbert Raskin, M.D., September 28, at 8 p.m. at the McGregor Building.

In Brief:

FLINT—The Genesee County Medical Society has planned an interested membership program for October 1 when the Presidents of the Michigan State Medical Society and the Michigan State Dental Association will both be honored guests. The Genesee MDs will be hosts that night for members of the county dental society.

* * *

LANSING — Governor Romney has appointed Edward H. Rodda, M.D., MSMS Councilor from Bay City, to the Advisory Council on Mental Health Services. The appointment, subject to Senate confirmation, is until January 1966. The vacancy was created by the recent resignation of Gelmer A. Van Noord, M.D., Grand Rapids.

Doctor Rodda was program chairman for the recent MSMS Mental Health Congress in Detroit.

* * *

CHICAGO—The current issue of the AMA publication, "PR DOCTOR," cites the MSMS Awards Program as a good example for other states to consider. In part, the article points out that the MSMS Awards (given annually at the County Secretaries-Public Relations Seminar) provide "an excellent means of giving due recognition to deserving individuals and organizations."

* * *

SAGINAW—Plans are fast taking shape for the Saginaw County Medical Society exhibit at the Saginaw County Fair September 13-19. MSMS is assisting with the exhibit —which will be an effective public relations project.

Offer High-Limit Accident Policy To All Members

Final arrangements are now complete to offer a special high-limit accident policy to MSMS members.

The new plan will pay up to $100,000 for accidental loss of life, limb or eyesight. The premium for this high limit coverage is understood to be the lowest ever offered for comparable benefits.

An announcement with a brochure outlining the new plan will be mailed in the near future.

Malcolm D. MacQueen, M.D., Detroit, Chairman of the MSMS Committee on Professional Insurance Plans, reports that details are being handled by MSMS Insurance Administrator, Ben P. Stratton. The carrier is Provident Life and Accident Insurance Company.

Paregoric, Intoxication Test, Abused Child Laws in Effect

Three bills passed by the 1964 State Legislature became law on August 28, ninety days following legislative adjournment. A proposal that it be mandatory for the purchaser of paregoric to produce a non-refillable prescription was supported by the MSMS Committee on Alcoholism and Drug Addiction. The prescription may be either written or oral, and the physician or dentist issuing the prescription must maintain the same records in connection with paregoric as previously maintained for other non-exempt narcotic drugs.

When a physician telephones a prescription the record will be maintained by the pharmacist and the doctor need not keep one, but he must maintain a record if he dispenses the paregoric himself.

MSMS endorsed a second proposal, now law, which requires all physicians who provide medical treatment, or examine, children under the age of 17 with injuries which *may have been intentionally inflicted* to report same to the prosecuting attorney *and* to the county department of Social Welfare. In so reporting the physician is guaranteed by law immunity from civil or criminal liability. If the possible abuse is detected by a physician who is acting as a member of a hospital staff, the report must be made by the person in charge of the hospital.

Failure by the physician is a misdemeanor.

It is now legally possible in Michigan to determine intoxication related to driving a motor vehicle by examination of urine, breath or other bodily substances, in addition to blood. Furthermore, where blood tests are made the blood can now be withdrawn by either a licensed nurse or a medical technician if a police officer requests it and it is done at the direction (with the approval of) a licensed physician.

It is not necessary for the physician to be physically present to supervise the withdrawal of blood.

List Medical Schools PG Offerings

Michigan physicians will have many opportunities this fall and coming school year to enroll in fine postgraduate courses and conferences presented by the medical schools of the University of Michigan and Wayne State University.

Added to these scheduled activities will be the excellent MSMS Postgraduate programs and clinics across the state. The MSMS Postgraduate Education Committee is enthusiastic about some innovations that will be added this fall and expanded next spring. Many of the ancillary groups also plan fine postgraduate events.

Information about the many university postgraduate efforts may be obtained from the medical schools.

University of Michigan
Department of Postgraduate Medicine
John M. Sheldon, M.D., Director

CONTINUOUS PROGRAMS:
- Pathology, Sept. 8-Nov. 18
- Cardiac Resuscitation, Oct. 26
- Clinical Electromyography, Nov. 19-20
- Physiology, Jan. 11-15
- Pediatrics, Jan. 18-30
- Obst. and Gynec., Jan. 20-22
- Diseases of the Blood, Jan. 25-29
- Nuclear Medicine, Feb. 1-3
- Hypertension, Renal and Vascular Disease, Feb. 8-12
- Psychiatry, Feb. 15-17
- Clinical Neurology, Mar. 1-2
- Infertility and Endocrinology, Mar. 4-5
- Diseases of the Heart, Mar. 8-12
- Electrocardiographic Diagnosis, Mar. 15-19
- Allergy, Mar. 22-24
- Rheumatology, Mar. 29-Apr. 2
- Obstetrics and Gynecologic Pathology, Mar. 29-Apr. 9
- Pulmonary Diseases, Apr. 5-7
- Surgical Anatomy, Apr. 5-May 14
- Diagnostic Radiology, Apr. 12-14
- Obstetric and Gynecologic Anatomy, Apr. 12-23
- Otorhinolaryngology Conference, Apr. 15-17
- Ophthalmology Conf., Apr. 19-21
- Endocrinology and Metabolism, Apr. 19-23
- Dermatology, Apr. 28-30
- Recent Advances in Therapeutics, May 3-7

INTERMITTENT PROGRAMS:
- Electrocardiography & Heart Disease, Tuesday evening, Sept. 1-Dec. 8
- Clinical Internal Medicine, Thursday afternoon, Sept. 3-Dec. 17
- Clinical Internal Medicine (Wayne Co. Gen), Wednesday afternoon, Sept. 30-Jan. 13 and Jan. 20-Apr. 14
- Selected Clinical Topics in Internal Medicine, Tuesday evening, Jan. 5-Apr. 13
- Anatomy, Thursday afternoon, Jan. 21-May 6
- Psychiatry for Pediatricians, Wednesday afternoon, Feb. 17-May 5

Wayne State University
Alexander Walt, M.D., Assistant Dean
- Neurosurgery Clinical, July 31-June 4
- Gynecology Grand Rounds (Receiving), Sept. 4-Dec. 18
- Obstetric Grand Rounds (Woman's), Sept. 1-Dec. 22
- Neurology Grand Rounds (Receiving), Sept. 9-Dec. 23
- Neurology X-ray Conference, Sept. 7-Dec. 21
- Electroencephalography Conference, Sept. 10-Dec. 17
- Neurology Grand Rounds (Harper), Sept. 11-Dec. 18
- Neurology - Clinical Teaching Conference, Sept. 26-May 15
- Surgical Radiological Conference, Sept. 12-May 29
- General Surgical Conference, Sept. 12-May 29
- Endocrine Conference, Sept. 15-May 25
- Internal Med., Oct. 10-May 22
- Medical - Surgical Gastroenterologic Conf., Oct. 10-May 22
- Medical-Surgical Cardiac Conference, Sept. 7-May 24
- Cardiology Seminar, Oct. 2-June 11
- Ophthalmology (Basic), Sept. 21-June 1
- Pathology (Surgical), Sept. 30-Dec. 12
- Pathologic Anatomy Seminar, Sept. 24-Dec. 12
- Path. (Basic), Sept. 21-Dec. 5
- Physiological Chemistry Seminar, Sept. 28-Dec. 7
- Intermediary Metabolism, Sept. 28-Dec. 7
- Biochemical Application of Radioactive Isotopes, Sept. 28-Dec. 9
- Dermatology (Histopathology Slide Review), Sept. 30-Mar. 3
- Anesthesia, Oct. 6-May 26
- Anatomy (Head & Neck), Oct. 6-Dec. 15
- Anatomy (Thorax, Abdomen and Pelvis), Oct. 7-Dec. 16
- Anatomy (Back and Limbs), Oct. 1-Dec. 10
- Psychiatry, Nov. 17-April ?

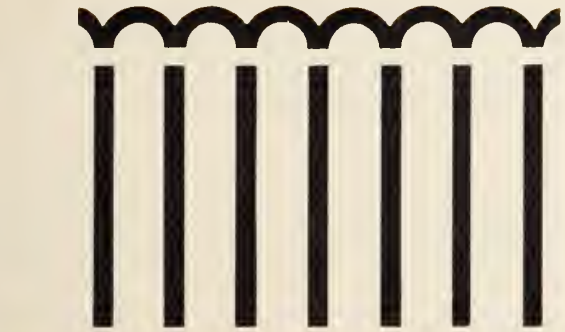
Announce Art Show Judges; Entries Due September 21-22

The judges for the 1964 Art Exhibit for Michigan doctors and their wives—to be held in Detroit during the Annual Session—are announced by Mrs. L. Jerome Fink, chairman.

Michael Church, supervisor of special projects, University of Michigan Extension Service, and Arthur Poinier, editorial cartoonist, *Detroit News*, have offered their services to judge the art work.

The Art Exhibit will take place September 22-23-24, at the Sheraton-Cadillac Hotel, in conjunction with the annual meetings of MSMS and its Woman's Auxiliary.

Interested doctors and their wives are invited to bring their entries to the Hotel between 9 a.m. and noon, September 22. The Show will be open September 22 from 3 to 6 p.m.; on September 23 from 9:30 a.m. to 6 p.m.; and on September 24 from 9:30 a.m. to 12 noon. Coffee will be served and the public is invited.



OUR STATE SOCIETY

MANY MSMS MEMBERS SERVE EFFECTIVELY ON BUSY COMMITTEES OF THE AMA

MSMS members continue to make valuable contributions to the service program of the American Medical Association by serving on its various committees and commissions.

Delegates to the AMA from Michigan are: C. I. Owen, M.D., Detroit; G. W. Slagle, M.D., Battle Creek; D. N. Sweeny, Jr., M.D., Detroit; J. R. Heidenreich, M.D., Daggett; W. A. Hyland, M.D., Chairman, Grand Rapids; O. J. Johnson, M.D., Bay City, and L. R. Leader, M.D., Birmingham.

The following are alternate delegates: E. E. Martmer, M.D., Grosse Pointe; R. E. Rice, M.D., Greenville; A. Hazen Price, M.D., Detroit; Sidney Adler, M.D., Detroit; G. B. Saltonstall, M.D., Charlevoix; B. M. Harris, M.D., Ypsilanti, and L. A. Drolett, M.D., Lansing.

Serving on various committees of the AMA are William Beierwaltes, M.D., Ann Arbor, Nuclear Medicine; Arthur Curtis, M.D., Detroit, Residency Review for Dermatology; Muir Clapper, M.D., Detroit, Secretary, Section on Internal Medicine; Russell N. DeJong, M.D., Ann Arbor, Residency Review for Psychiatry and Neurology.

Harold Falls, M.D., Ann Arbor, Alternate Delegate to Section on Ophthalmology; Representing Ophthalmology on the Study of Coordinate Relationship of Medicine with Allied Professions. Jacques S. Gottlieb, M.D., Detroit, Residency Review for Psychiatry and Neurology; Albert E. Heustis, M.D., Lansing, Residency Review for Preventive Medicine; Leonard Himler, M.D., Ann Arbor, Joint Committees of the Councils, Chairman, Committee on Mental Health in Industry; Arthur A. Humphrey, M.D., Battle Creek, Consultant, Committee on Insurance and Prepayment Plans.

Others include William A. Hyland, M.D., Grand Rapids, Constitution and Bylaws Committee Chairman, Communications Chairman; Clarence S. Livingood, M.D., Detroit, Alternate Delegate to Section on Dermatology; Archives of Dermatology; Residency Review for Dermatology; Norman D. Nigro, M.D., Detroit, Residency Review for Colon and Rectal Surgery; Secretary, Section on Proctology. Bruce Proctor, M.D., Pontiac, Associate Editor of Otolaryngology; James W. Rae, Jr., M.D., Ann Arbor, Residency Review for Physical Medicine and Rehabilitation; Herbert A. Raskin, M.D., Detroit, Alcoholism and Addiction; William D. Robinson, M.D., Ann Arbor, Council on Foods and Nutrition.

Still other committee members are Richard C. Schneider, M.D., Ann Arbor, Medical Aspects of Sports; Maurice H. Seevers, M.D., Ann Arbor, Alcoholism and Addiction; George W. Slagle, M.D., Battle Creek, Vice Chairman and Council Representative to the Committee on Insurance and Prepayment Plans, Medical Practices, Liaison Committee of Council on Medical Education and Council on Medical Service.

Concluding the list are Frederick C. Swartz, M.D., Lansing, Chairman, Committee on Aging, National Council on Accreditation of Nursing Homes; Arthur J. Vorwald, M.D., Detroit, Committee on Rating of Mental and Physical Impairment; Franklin V. Wade, M.D., Flint, Committee on Fractures; Walter P. Work, M.D., Ann Arbor, Residency Review for Otolaryngology.

EDITOR'S NOTE

It is our understanding that more than 50 AMA positions are filled by Michigan physicians—and the AMA executive office points out that "MSMS participation rates high in relation to comparable states."

Every effort was made to obtain the names of every Michigan doctor serving on an AMA council, committee, sub-committee. Your assistance is requested to help us compile a perfect list.

Abstract of MSMS Council Action

Meeting of July 16-18, 1964

BLUE SHIELD MERIT RATING PROPOSAL

Following study of Michigan Medical Service proposed plan for merit rating, The Council indicated it looked with favor on merit rating in principle and recommended that all possible information on the subject be provided to MSMS Delegates and Alternate Delegates prior to the 1964 Session of the House.

MEETING WITH MICHIGAN CRIPPLED CHILDREN COMMISSION

In joint meeting with the Commission, The Council discussed items of mutual interest and heard a report that the Commission had removed regulations regarding consultation for elective surgery.

HONORARIA FOR OFFICERS

At the request of the House of Delegates, The Council studied the matter of honoraria for officers and will recommend to the House that the President, President-Elect and Chairman of The Council receive a special expense allowance, and that these officers automatically be elected to life Membership in MSMS upon completion of their term of office.

RETIREMENT PLAN PROPOSAL

The Council directed that more details of a plan that might be of interest to MSMS members be submitted to The Council for review.

1966 HEALTH FAIR

The Council recommended that all possible effort be made prior to the 1964 Session of the House of Delegates to raise necessary funds to produce the Health Fair.

MATERNAL AND PERINATAL WELFARE CONFERENCE

Upon recommendation of the MSMS Committee on Maternal Health, The Council recommended acceptance of the Clara Elizabeth Fund offer to finance future annual conferences.

MENTAL HEALTH COMMITTEE NEWSLETTER

Upon recommendation of the Mental Health Committee, The Council authorized the Committee to distribute two issues of a newsletter for the remainder of the committee year to physicians and lay people interested in mental health matters.

DISSOLUTION OF BEAUMONT MEMORIAL FOUNDATION

Upon recommendation of the Beaumont Memorial Foundation and with the advice of Legal Counsel, The Council accepted the assets of the Foundation and will appoint a committee to oversee the operation of existing assets in Beaumont House on Mackinac Island. Special thanks were given to Otto O. Beck, M.D., for his guidance and inspiration to the Beaumont project.

POLICY STATEMENT RE TRANSFER OF PROFESSIONAL SERVICE BENEFITS TO BLUE CROSS CONTRACTS

The Council adopted a policy statement objecting to transfer of professional service benefits to Blue Cross contracts and transmitted this statement to the boards of Michigan Hospital Service and Michigan Medical Service by appropriate letter.

STUDY OF AMA CONCEPT OF PUBLIC HEALTH

The Council adopted recommendations for altering the 1962 AMA House of Delegates definition and concept of public health.

PRINCIPLES AND GUIDELINES FOR PHARMACEUTICAL SERVICES IN HOSPITALS

Following thorough review of principles developed by the Michigan Hospital Association and Michigan Pharmaceutical Association, The Council authorized the Michigan Hospital Association to indicate MSMS approval of these suggested Principles and Guidelines.

PUBLICATION OF MSMS DIRECTORY

Upon recommendation of the Publication Committee The Council authorized the MSMS Directory to be published in October and that efforts be made to sell advertising space in this publication.

NATIONAL ASSOCIATION OF SCIENCE WRITERS

The Council approved of Scientific Editor C. J. Tupper, MD, becoming a member of this organization.

REPORT ON CONGRESS ON MENTAL ILLNESS AND HEALTH

The Council received a detailed report of the MSMS Congress on Mental Illness and Health held in Detroit in June. The Council expressed high commendation to Edward H. Rodda, M.D., and Benjamin Jeffries, M.D., and the MSMS staff who contributed in making the Congress a success.

PRELIMINARY DRAFT OF THE ANNUAL REPORT OF THE COUNCIL

The Council approved the preliminary draft of the Annual Report of The Council to be presented to Delegates and Alternate Delegates at Councilor Conferences. The final Annual Report of The Council will be presented to the Delegates at the 1964 Session.

Michigan Physicians Head National Organizations

Two Michigan men recently were installed as presidents of national specialty organizations.

Brock E. Brush, M.D., Detroit, is serving as president of the American Geriatrics Society.

D. Emerick Szilagyi, M.D., Detroit, is president of the International Cardiovascular Society.



B. E. Brush, M.D.



D. Emerick Szilagyi, M.D.

Three other Michigan physicians were named at the AMA Section Meetings in San Francisco to major offices.

E. Richard Harrell, Jr., M.D., Ann Arbor, is Vice Chairman of the Dermatology Section; Muir Clapper, M.D., Detroit, Secretary of Internal Medicine Section, and Harold J. Magnuson, M.D., Ann Arbor, Vice Chairman of Preventive Medicine Section.

Niagara Gets Copy Of Cornwell Painting

Visitors at the Old Fort Niagara, New York, beginning this month will see a reproduction of Dean Cornwell's famous painting, "Beaumont and St. Martin."

Wyeth Laboratories, which gave the original Cornwell painting to MSMS for the Beaumont Memorial at Mackinac Island, recently gave a copy of it to the Medical Society of the County of Niagara for the old fort there.

Doctor Beaumont served at Fort Niagara after he served at Mackinac.

ON AMA CALENDAR

The AMA Residency Review Committee for Psychiatry and Neurology, of the Council on Medical Education, will meet at the Whittier Hotel, Detroit, October 9-10.

U-M NAMES RESEARCH VEEP

A. Geoffrey Norman, professor of botany and director of the U-M Botanical Gardens, began duties August 1, as the Vice President for Research of the University of Michigan. During the past year, Professor Norman has been on leave in Washington acting as Advisor on the Life Sciences to the President of the National Academy of Sciences.



PROGRAMS FOR ANCILLARY GROUPS

Added Detroit Highlights, September 23-24-25

Wednesday, September 23

THE MSMS SECTION ON ANESTHESIOLOGY AND THE MICHIGAN SOCIETY OF ANESTHESIOLOGISTS will meet jointly on Wednesday, September 23, 1964, beginning with reception and luncheon meeting at 12:00 noon in the East-West Room of the Sheraton-Cadillac Hotel in Detroit, Virginia Apgar, M.D., of New York City, will talk on "What the Anesthesiologist Can Contribute to the Welfare of the Newborn."

For reservations, contact John D. Snider, M.D., 1810 Wealthy St., S.E., Grand Rapids.

THE MSMS SECTION ON DERMATOLOGY will meet on Wednesday, September 23, 1964, beginning with luncheon at 12:00 noon in the Sheraton Room of the Sheraton-Cadillac Hotel in Detroit. Carl E. Arbesman, M.D., of Buffalo, New York, will talk on "Allergy to Drugs."

For details and luncheon reservation, please write Secretary Robert J. Schoenfeld, M.D., 794 N. Woodward Ave., Birmingham.

THE MICHIGAN DIABETES ASSOCIATION will hold its Annual Scientific Session on Wednesday, September 23, 1964, at the Sheraton-Cadillac Hotel in Detroit.

Program

Afternoon Meeting

P.M.

1:30-4:30—Boulevard Room

1:30 *Moderator:* KEATS K. VINING, JR., M.D., Grand Rapids, Chairman, Clinical Division
HARVEY C. KNOWLES, JR., M.D., Professor of Medicine, University of Cincinnati College of Medicine.
"Relationship of the Control of Diabetes to the Angiopathies of Diabetes."

2:00 VICTOR E. POLLACK, M.D., Department of Medicine, Presbyterian St. Luke's Hospital, Chicago, Illinois.
"The Renal Complications of Diabetes."

2:30 JOHN BRYAN, M.D., Department of Endocrinology and Metabolism, Henry Ford Hospital, Detroit.
"Problems in Early Treatment of Diabetes"

3:00 RACHMIEL LEVINE, M.D., Professor and Chairman, Department of Medicine, New York Medical College, New York City.
"The Biochemical Lesions of Diabetes Mellitus."

3:30 Panel discussion by essayists on
"Is 'Control' Really Control?"

Evening Sessions

6:00 Reception—Washington Room

7:00 Dinner—Woodward Room
Master of Ceremonies:
JOHN BRYAN, M.D., President, Michigan Diabetes Association
Speaker:
RACHMIEL LEVINE, M.D., New York City

* * *

For details, and reservation for the dinner, contact Keats K. Vining, Jr., M.D., 3919 John R., Detroit 1.

THE MSMS SECTION ON GASTROENTEROLOGY AND PROCTOLOGY will meet on Wednesday, September 23, 1964, beginning with luncheon at 12:30 p.m. in the Washington Room of the Sheraton-Cadillac Hotel, Detroit. The speaker is Howard F. Raskin, M.D., of Baltimore, who will present "Frustrations and Successes in the Detection of Occult Bleeding Sites of the Gastrointestinal Tract."

For full details and luncheon tickets, please write Chairman Joseph Rinaldo, Jr., M.D., Henry Ford Hospital, Detroit 2.

THE MSMS SECTION ON GENERAL PRACTICE will meet on Wednesday, September 23, 1964 at 5:30 p.m. in the Boulevard Room of the Sheraton-Cadillac Hotel in Detroit. George B. Logan, M.D., of Rochester, Minnesota, will speak on a topic of value in the generalist's care of the pediatric patient.

The Board of Directors of the **MICHIGAN ACADEMY OF GENERAL PRACTICE** will meet on Wednesday, September 23, 12:00 noon luncheon-meeting in the Mason Room of the Sheraton-Cadillac Hotel in Detroit.

THE MSMS SECTION ON INTERNAL MEDICINE will meet on Wednesday, September 23, 1964, beginning

at 5:45 p.m. and followed by a reception at 7:00 p.m. in the East and West Rooms of the Sheraton-Cadillac Hotel in Detroit. The speaker is Paul M. Seebohm, M.D., of Iowa City, Iowa, who will talk on "Bronchial Asthma with Emphysema vs. Emphysema with Asthmatic Bronchitis."

For details please write Clayton K. Stroup, M.D., 2002 E. Court, Flint 3.

THE MSMS SECTION ON NERVOUS AND MENTAL DISEASES AND THE MICHIGAN SOCIETY OF NEUROLOGY AND PSYCHIATRY AND MICHIGAN DISTRICT BRANCH, AMERICAN PSYCHIATRIC ASSOCIATION will meet jointly on Wednesday, September 23, 1964, beginning with cocktails at 6:00 p.m. and followed by a dinner and meeting in the English Room of the Sheraton-Cadillac Hotel in Detroit. Robert A. Kimmich, M.D., Lansing, Director of the Michigan Department of Mental Health, will present "Michigan's Mental Health—1965." The discussants are Peter A. Martin, M.D. and Benjamin Jeffries, M.D., of Detroit.

For details and dinner ticket please contact Victor W. Kershul, M.D., Box A, Ypsilanti.

THE MICHIGAN ORTHOPAEDIC SOCIETY will meet on Wednesday, September 23, 1964, at the University Club in Detroit. Reception at 6:30 p.m. and dinner at 7:30 p.m. The speaker is James B. Wray, M.D., Syracuse, on "Clinical Applications of Recent Research in Fracture Healing."

THE MSMS SECTION ON OTOLARYNGOLOGY AND THE DETROIT OTOLARYNGOLOGY SOCIETY will meet on Wednesday, September 23, 1964, beginning with cocktails at 6:00 p.m., dinner at 7:00 p.m., and a Section business meeting of the Detroit Otolaryngology Society. Speaker of the evening is Fred W. Alexander, M.D., of Cleveland, Ohio, who will talk on "Irradiation and the Larynx". The entire meeting will be held in the Sheraton Room of the Sheraton-Cadillac Hotel in Detroit.

For details write D. F. Weaver, M.D., 571 Fisher Building, Detroit 2. Dinner ticket can be purchased at the time of the dinner.

THE MICHIGAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION will meet on Wednesday, September 23, 1964, for a 6:00 p.m. dinner-meeting in Rooms 907 and 908 of the Sheraton-Cadillac Hotel in Detroit.

For details please contact Frederic B. House, M.D., St. Joseph Mercy Hospital, Ann Arbor.

THE MSMS SECTION ON OBSTETRICS AND GYNECOLOGY will meet on Wednesday, September 23, beginning with luncheon at 12:00 noon in the English Room of the Sheraton-Cadillac Hotel, Detroit. Following luncheon, J. Robert Willson, M.D., of Ann Arbor, will talk on "The Responsibility of the Physician in Family Planning." The meeting will adjourn at 2:00 p.m.

For details and luncheon ticket, please contact Secretary Russell J. Paalman, M.D., 36 Sheldon Avenue, S.E., Grand Rapids 2.

THE MSMS SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE will meet on Wednesday, September 23, 1964, in Rooms 807-808 Sheraton-Cadillac Hotel, Detroit, beginning with cocktails at 12:30 p.m., luncheon at 1:00 p.m., to be followed by a talk to be presented by Robert A. Kimmich, M.D., Lansing, the new Director of the Michigan Department of Mental Health, who will discuss the physician's responsibility in the preventive mental health program.

For details and luncheon ticket, please contact Chairman G. Frederick Moench, M.D., 301 W. Main St., Midland.

THE MSMS SECTION ON RADIOLOGY AND THE DETROIT ROENTGEN RAY SOCIETY will meet jointly on Wednesday, September 23, 1964, beginning with cocktails and dinner at 6:15 p.m. in the Grand Ballroom of the Sheraton-Cadillac Hotel in Detroit. Speaker of the evening is Robert D. Moseley, Jr., M.D., of Chicago, Illinois.

For details and dinner ticket, please write Karl K. Latteler, M.D., 15025 West Eight Mile Road, Detroit 35.

THE MSMS SECTION ON SURGERY will meet on Wednesday, September 23, 1964, beginning with cocktails and dinner at 5:30 p.m. in the Book-Casino of the Sheraton-Cadillac Hotel in Detroit. Speaker of the evening is Robert P. Gilbert, M.D., of Evanston, Illinois.

For details and dinner ticket please contact Benjamin E. Henig, M.D., at Grayling, Michigan. Wives, husbands and escorts are invited.

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION—The Wayne State University School of Medicine Alumni Association will hold an Open House on Wednesday, September 23, at the Sheraton-Cadillac Hotel in the Wayne State University Alumni Suite. Representatives of the University will be in attendance. All alumni, faculty, and friends are cordially invited. Cocktails and hors d' oeuvres will be served from 4:00 p.m. to 6:00 p.m.

The Wayne State University School of Medicine Alumni Association will also maintain a Headquarters Suite in the Hotel on September 23 and 24.

THE JOINT MEETING OF THE MSMS SECTION ON UROLOGY AND THE DETROIT BRANCH OF THE AMERICAN UROLOGICAL ASSOCIATION will be held on Wednesday, September 23, 1964, beginning at 2:00 p.m. at the Wayne County Medical Society, Detroit.

Reception and dinner meeting will begin at 5:30 p.m.

THE MICHIGAN PROCTOLOGIC SOCIETY will hold a dinner and business meeting on Wednesday, September 23, in Rooms 807-808 of the Sheraton-Cadillac Hotel, Detroit.

For details, please contact T. C. Arminski, M.D., 1066 Fisher Building, Detroit 2.

According to Lynn A. Ferguson, M.D., the **ALPHA KAPPA KAPPAS** will get together on Wednesday, September 23. Definite arrangements will be announced at a later date.

Thursday, September 24

THE MSMS SECTION ON OCCUPATIONAL MEDICINE will meet on Thursday, September 24, 1964, beginning at 5:00 p.m. and followed by a reception at 6:00 p.m. in the Washington Room of the Sheraton-Cadillac Hotel in Detroit. Speaker of the evening is Harold J. Magnuson, M.D., of the Institute of Industrial Health in Ann Arbor. Doctor Magnuson will talk on "Training in Occupational Medicine."

For details please write W. L. Berridge, Jr., M.D., Chevrolet Motor Company, Livonia.

THE MSMS SECTION ON OPHTHALMOLOGY will meet on Thursday, September 24, 1964, beginning at 5:30 p.m. and followed by a reception at 6:30 p.m. in the Sheraton Room of the Sheraton-Cadillac Hotel in Detroit. Malcolm A. McCannel, M.D., Minneapolis, Minnesota, will talk on "Tropical Ophthalmology."

For details, please contact James L. Frey, M.D., 1553 Woodward Avenue, Detroit.

THE MICHIGAN ACADEMY OF PLASTIC SURGERY will meet on Thursday, September 24, 1964, in the East and West Rooms of the Sheraton-Cadillac Hotel in Detroit, beginning at 4:00 p.m., with a reception at 6:00 p.m. and dinner at 6:30 p.m. There will also be an evening meeting from 7:00 to 9:00 p.m.

For details, please write Ralph Blocksma, M.D., 245 State St., S.E., Grand Rapids.

THE MICHIGAN CHAPTER, COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS will meet on Thursday, September 24, 1964, beginning with a 12:30 p.m. reception and luncheon in the Sheraton Room of the Sheraton-Cadillac Hotel in Detroit.

For details, write Franklin V. Wade, M.D., 1121 Mott Building, Flint.

THE VANDERBILT ALUMNI ASSOCIATION will meet for a luncheon-meeting at 12:00 noon on Thursday, September 24, 1964, in the Washington Room of the Sheraton-Cadillac Hotel in Detroit.

Friday, September 25

THE MSMS SECTION ON PATHOLOGY AND THE MICHIGAN SOCIETY OF PATHOLOGISTS will meet jointly on Friday, September 25, 1964, beginning with a business meeting at 10:00 a.m. in the Boulevard Room of the Sheraton-Cadillac Hotel in Detroit. A reception and luncheon is scheduled for 12:30 p.m.—the reception will be in the Sheraton Room with luncheon in the Washington Room. The 2:00 to 5:00 p.m. afternoon meeting will be held in the Woodward Room. At this time, Leopold G. Koss, M.D., Attending Pathologist, and Chief, Cytology Service, Memorial Hospital for Cancer and Allied Diseases, New York City, will conduct a seminar on "Diagnostic Cytology." The seminar will deal with problems of diagnosis based on microscopic examination of cells. Eighteen illustrative cases will be presented covering various applications of the cytologic techniques.

For details and reservation, please contact James G. Wolter, M.D., 6071 W. Outer Drive, Detroit.

THE MSMS SECTION ON PEDIATRICS AND THE MICHIGAN BRANCH OF THE AMERICAN ACADEMY OF PEDIATRICS will meet jointly on Friday, September 25, 1964, at the Sheraton-Cadillac Hotel in Detroit.

Program

Afternoon Meeting

P.M.

2:00 to 5:00 Grand Ballroom
Panel discussion on "Endocrine Problems in Adolescence"

Moderator: Richard R. Galpin, M.D., Clinical Instructor, Department of Pediatrics, Wayne State University School of Medicine, Detroit.

Panelists:

J. Roswell Gallagher, M.D., Chief of Adolescent Unit, Children's Medical Center, Boston, Massachusetts.

Lytt I. Gardner, M.D., Professor of Pediatrics, State University of New York College of Medicine, Syracuse, New York.

Joseph A. Johnston, M.D., Pediatrician-in-Chief, Henry Ford Hospital, Detroit.

Raymond C. Mellinger, M.D., Associate, Division of Endocrinology, Henry Ford Hospital, Detroit.

Topics:

Obesity in Girls and Boys and Hazards of Dieting
Hyperthyroidism
Menstrual Irregularities
Growth Abnormalities: "Too Tall," "Too Slow," et cetera
"Cerebral Gigantism!"

Evening Sessions

6:00 Reception—Book-Casino

7:00 Dinner—Book-Casino

8:00 "Adolescence in Modern and Ancient Times or Who Needs Sparta?"
Elton McNeil, Ph.D., Director of the University of Michigan Fresh Air Camp and Chairman of the Graduate Programs in Psychology, University of Michigan, Ann Arbor.

For details and dinner ticket, please contact Irving Posner, M.D., 20211 Greenfield Rd., Detroit 35. All Registrants at the MSMS Annual Session are cordially invited to attend.

1964 MSMS Annual Session Exhibitors

Abbott Laboratories
Aloe Medical, Division of Brunswick
Americana Corporation
Ames Company, Inc.
Armour Pharmaceutical Company
Astra Pharmaceutical Products, Inc.
Ayerst Laboratories

Borcherdt Company
Bristol Laboratories
The Borden Company
Burroughs Wellcome & Company

Carnation Company
Ciba Pharmaceutical Products, Inc.
Coca-Cola Company
Cottrell-Clarke, Inc.

Dome Chemical Incorporated
Doyle Pharmaceutical Company

Eaton Laboratories, Inc.
Encyclopaedia Britannica

Ferndale Surgical, Inc.

Geigy Pharmaceutical
Gerber Products Company
Great Books of the Western World

Hack Shoe Company

G. A. Ingram Company

Johnson & Johnson

Knoll Pharmaceutical Company
A. Kuhlman & Company

Lederle Laboratories
Eli Lilly & Company
J. B. Lippincott Company
Lloyd Brothers, Inc.
P. Lorillard Company

Maico Hearing Service
Marion Laboratories, Inc.
McNeil Laboratories, Inc.
Mead Johnson Laboratories
Medical Arts Supply Company
Medical Protective Company
Merck Sharp & Dohme
Meyer Laboratories
Michigan Medical Service

Ortho Pharmaceutical Corporation

Pacific Medical Equipment Company
Parke, Davis & Company
Procter & Gamble Company
Professional Management

Randolph Surgical Supply Company
R. J. Reynolds Tobacco Company
A. H. Robins Company, Inc.
Roche Laboratories
J. B. Roerig & Company
Wm. H. Rorer, Inc.

Ross Laboratories
Rupp & Bowman Company

Sanborn Company
Sandoz Pharmaceuticals
W. B. Saunders Company
Schering Corporation
Julius Schmid, Inc.
G. D. Searle & Company
Seven-Up Developers of Michigan
Smith Kline & French Laboratories
Smith, Miller & Patch, Inc.
E. R. Squibb & Sons
Strasenburgh Laboratories
Ben Stratton Insurance
The Stuart Company
Syntex Laboratories, Inc.

S. J. Tutag & Company

United States Tobacco Company
U. S. Vitamin & Pharmaceutical Corporation
The Upjohn Company

Wallace Laboratories
Warren-Teed Products Company
Westwood Pharmaceuticals
White Laboratories
Winthrop Laboratories, Inc.
W-T-S Pharmaceuticals

(More on Page 658)



The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

METAMUCIL® brand of psyllium hydrophilic mucilloid

"Diverticulosis ... a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"Diverticulitis Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil...."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine

Say you saw it in Michigan Medicine

WOMAN'S AUXILIARY, MICHIGAN STATE MEDICAL SOCIETY

Thirty-eighth Annual Meeting
Pick-Fort Shelby Hotel, Detroit
September 22-24, 1964

Program

Tuesday, September 22, 1964

M

12:00 Registration opens.

P.M.

1:30 Planning Conference and Executive Committee Meeting for 1963-64 and 1964-65 State Officers. Directors and Chairmen.

6:30 Past Presidents Banquet—Woman's City Club.

Wednesday, September 23, 1964

A.M.

9:00 Continental Breakfast.

9:30 Opening Session:

Call to Order: Mrs. R. J. Himmelberger, President.

Welcome: Mrs. John Rebuck, President, Wayne County Auxiliary.

Introduction of Convention Chairman: Mrs. Earl Weston, Chairman.

President's Address: Mrs. R. J. Himmelberger.

Reports of Officers

Program Session:

"Better Health—Better World" National Theme for 1964-1965, by State Committee Chairmen.

P.M.

12:30 Luncheon—Honoring Mrs. William Evans, President of the Woman's Auxiliary to the American Medical Association; Mrs. William Mackersie, Past President of the Woman's Auxiliary to the AMA; Mrs. Leo Parnagian, Past President of the Woman's Auxiliary to the Student AMA; Past Presidents of the Woman's Auxiliary of the Michigan State Medical Society; Representatives of the Michigan State Medical Society; the Wayne County Medical Society and Honored Guests.

Convention Address: Mrs. William E. Evans

Thurday, September 24, 1964

A.M.

9:00 Continental Breakfast.

9:30 General Session.

Memorial Service.

County Presidents' Reports, "The Year Past."

Election of Officers.

Meeting of the Executive Committee (1964-1965).

P.M.

12:30 Inaugural Luncheon.

Installation of Officers.

Inaugural Address—Mrs. Milton Weed.

2:30 Post Convention Board Meeting and Planning Session. For all 1964-1965 Elected Officers, District Directors, State Chairmen, and County Presidents.

MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

Fifteenth Annual Convention
The Statler-Hilton Hotel, Detroit
September 23, 24, 1964

"MEDICINE AND RELIGION"

Wednesday, September 23, 1964

A.M.

9:00 Registration—Ballroom Foyer.

10:00 House of Delegates Meeting—Wayne Room

10:15 Movie—"Poison Proofing Our Communities"—Ivory Room (Mr. Douglas Vivian).

P.M.

12:30 Luncheon—Grand Ballroom

Welcome—Mrs. Dorothy Brandis, President, MSMAS.

Speaker—Albert E. Heustis, M.D., State Health Commissioner, Lansing, Michigan.

Topic—"A Job To Be Done."

6:30 Social Hour—Courtesy Parke Davis and Co.—Michigan Room

7:30 Banquet—Wayne Room

Speaker: Edgar A. Guest, Jr., "On the Sunny Side of the Street."

Thursday, September 24, 1964

A.M.

9:00 Registration—Wayne Room Foyer

10:15 Panel: "The Patient Is a Whole Person." Moderated by Rev. Dr. Paul B. McCleave, Director of AMA Department of Medicine and Religion.

P.M.

12:30 Luncheon—Bagley Room

Speaker: Theodore John Lukens, M.D., Palos Verdes, California.

Topic: "What Complicates Your Life with Your Employer."

Presentation of Medical Assistant of the Year Award.

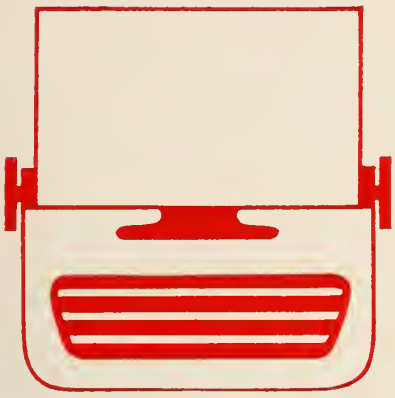
Presentation of Membership Trophy.

Presentation of Bulletin Award.

Presentation of Certificates for In-Service Training.

Installation of Officers—Mrs. Bettye Fisher, Past President, American Association Medical Assistants.

Address by Miss Phyllis Marquardt, Incoming President



EDITORIAL VIEWS

We Want Letters

By John J. Coury, M.D.,
Vice Chairman, Publication Committee

It has been said that there are at least five reasons that may motivate a person to write—

1. One writes because it is a form of creativity.
2. One writes because he has something to say.
3. One writes because he may sell the article.
4. One writes because he thinks he is an author.
5. One writes because he wants to be read.

Readership surveys almost always reveal that the "Letters to the Editor" column has the biggest following. Therefore, we invite any MSMS member to sit down and write a letter to the editor. Tell us your views on some issue. Write and take the other side of some question. Ask some questions about some current issue, et cetera.

If you do, you'll score well on Reason Number 5 above, to say nothing of Reasons 1, 2, and 4. (However, you will not cash in on Number 3!)

Merely address your letter to C. J. Tupper, M.D., Editor, MSMS, Box 152, East Lansing, Michigan.

Thanks, Doctor Beck

By Robert J. Mason, M.D.,
Vice Chairman, MSMS Council

The doctors of Michigan honored one of their greatest colleagues and at the same time provided a permanent educational exhibit for the thousands of visitors to Mackinac Island when it reconstructed there the American Fur Trading Store. As most doctors know, it was in this store that Alexis St. Martin, a French Voyageur, received a gunshot wound which developed into a fistula that in turn provided Dr. William Beaumont with an opportunity to study the digestive processes in the stomach.

From the beginning of this reconstruction of the Beaumont Memorial Building to the present has occupied nearly 15 years of time. Doctors such as Frederick A. Coller, Alfred H. Whittaker, L. Fernald Foster and many others deserve recognition for the inception and development of this educational project.

Although the entire project was carried out under the aegis of the Michigan State Medical Society the actual formulation and implementation of the plans was the handiwork of the Beaumont Foundation. Chairman of this Foundation from its beginning was Otto O. Beck, M.D., of Birmingham.

Dr. Beck recently asked The Council to accept the assets of the Beaumont Foundation which include the contents of the Beaumont Memorial and directly take over their supervision. The Council agreed to do so. Thus endeth the planning, building, equipping and the placing in operation of a significant educational project.

It is a job well done.

Although hundreds of doctors of medicine in Michigan contributed their money and many others were active in the work involved, the key man, the man who accepted the responsibility, made the decisions, worried about details and generally supervised the whole operation was Otto O. Beck, M.D.

The occasion for the change in operation and administration is an occasion well suited to an expression by the State Medical Society of its pride in Dr. Beck and its appreciation to him for his outstanding service.

Keeping Doctors Up to Date

(*New York Times*, July 12, 1964)

A series of articles in the current issue of *The Journal of the American Medical Association* testifies to the keen concern of the nation's medical profession with the enormous problem of keeping doctors up to date. The core of the difficulty is the rapid proliferation of new knowledge in every area of medicine. How is this new knowledge to be brought most rapidly and most effectively from the laboratories and other research centers where it is won to the firing line against illness and death—that is, to the points at which doctors and their patients come together?

Today the degree to which a physician in private practice keeps up to date depends largely on his own conscience, and the actual activities of individual physicians in this respect vary widely. At one extreme are physicians who devote great amounts of energy and time to keeping abreast of the latest developments in their areas of interest —regularly attending medical meetings, reading current journals, and, where necessary, taking special courses. At the other extreme, no doubt, there are doctors who do little in this direction and who try to carry on their work over long professional lifetimes primarily with the knowledge gained during medical school, interneship and residency.

The symposium in the American Medical Association's organ suggests a growing dissatisfaction with this situation. The proposal that doctors be required to take periodic requalifying examinations—say, once a decade—to attest their continuing competence has no great support at the present time, but it could gain partisans. The more desirable alternative is the self-regulation of physicians by their own fraternity, a self-regulation designed to assure that every doctor fulfills his obligation to keep abreast of new developments. Even with the best of will the task is not easy and it grows more difficult as the tempestuous advances of research continue year after year.

AMA-ERF Aid Appreciated

By Lyman J. Smith,
AMA-ERF Director of Programs

Last year a young physician in St. Clair Shores wrote to the AMA Education and Research Foundation.

"Supporting a family and living a semi-comfortable life on an intern's stipend," he said "would be impossible were it not for your aid."

He said, further, that he had been able "to select an internship at a hospital where the training is excellent and the financial aspect moderate."

A. Kent Williams, M.D., now with the Navy in the Pacific, is one of thousands of medical students, interns and residents across the country who have been helped by AMA-ERF. The "aid" they have received, however, involves no subsidy. Rather, it is the chance to pay for their own medical training by borrowing money from banks on a long-term basis. Without the AMA-ERF Loan Guarantee Fund serving as collateral, most trainees would not be able to obtain such loans. In just two years, AMA-ERF had guaranteed nearly 13,000 loans worth more than $15 million in principal. In Michigan alone, as of December 31, 350 loans totalling $411,300 had been made.

The enthusiastic response with which young men and women in training greeted this program has not abated. Loan applications continue to pour in at a rate of well over 500 every month.

To keep pace with this demand, contributions still are needed for the Loan Guarantee Fund, which now exceeds $2 million. Banks can lend $12.50 for every $1 in the Fund. So far, industry has matched physician contributions dollar for dollar in building this Fund. Thus, your contribution is worth not $12.50 but $25 on the dollar when it provides incentive for corporate giving.

The Other AMA

In the minds of the public and of too many of our colleagues, the American Medical Association is identified as a political and economic organization.

It is of paramount importance that we recognize the social and educational contributions that our society has made as well. With the establishment of the AMA Medical Student Loan Fund, a clear demonstration has been made of the fact that private enterprise and voluntary effort can move effectively to solve a major problem.

Now the American Medical Association, through its establishment of the new Biomedical Institute, is demonstrating that research of the most basic type can also be accomplished on the basis of private enterprise without federal support. In an effort to promote all-out inquisitiveness at its Institute for Biomedical Research, now under construction, the AMA has decided to submerge business practices in favor of scientific independence. Roy E. Ritts, M.D., Director of the Institute, has stated, "We intend, as nearly as possible, to supply the investigator with whatever he feels is necessary to his work, then leave him alone to work as he sees fit."

One of the unique features of the Institute, which opens next year, will be the absence of research grants. Research grants have added great impetus to research in the past but have been criticized as being too confining, as committing a scientist to a pre-determined line of inquiry, and as being increasingly complicated by paper work, cost accounting, time studies, etc. Interferences of this type will not bother the scientist appointed to the Biomedical Institute. These scientists will receive "superior salaries," will hold lifetime positions if they so choose, and will be furnished all equipment and facilities they need. The scientists' only obligation will be to prepare a budget and work summary once a year and to attend staff seminars. His only restriction will be that his work must fall somewhere within the definition of "fundamental inquiries into basic life processes." The emphasis will be on basic original research and any discoveries will be offered free to all.

Once again, we have reason to look upon our membership in the American Medical Association with pride, as it continues its effort to develop new knowledge for the betterment of mankind.

Ask Counties Work Now On Centennial News

How effective the spotlight can be focused on the medical profession in Michigan during the MSMS Centennial in 1965-66 will depend upon each county society to a large degree.

It is time now for each county society to appoint a member or committee to check through the past century of service and obtain some story material.

What happened in your county in the past century to make medical history?

The history of medicine in Michigan is primarily a collection of these stories from the different counties. The full news media attention to the MSMS Centennial is a year away, so now is the time to do some research. Surely, you have a member or two who would enjoy such an opportunity.

MSMS will provide suggestions later to county societies suggesting ways to tie in their local medical histories with MSMS Centennial promotion.

LIST CALHOUN CLINIC SPEAKERS

The Calhoun County Medical Society announces an excellent program for the South Western Michigan Clinic Day, November 5, in Battle Creek.

This annual all-day meeting will present: Richard Bing, M.D., Detroit; Richard C. Lillehei, M.D., Minneapolis; Robert Good, M.D., Minneapolis; F. Mason Sones, M.D., Cleveland; Robert Zeigler, M.D., Detroit; Harold F. Falls, M.D., Ann Arbor; Jeremiah Stammler, M.D., Chicago, and William Hollander, M.D., Boston.

NORTHERN MICHIGAN TEACHES SAFETY

One of the fine community service projects this past summer was the Northern Michigan Medical Society co-sponsorship of courses for county water safety personnel, fire, police, sheriff's officers and other rescue personnel.

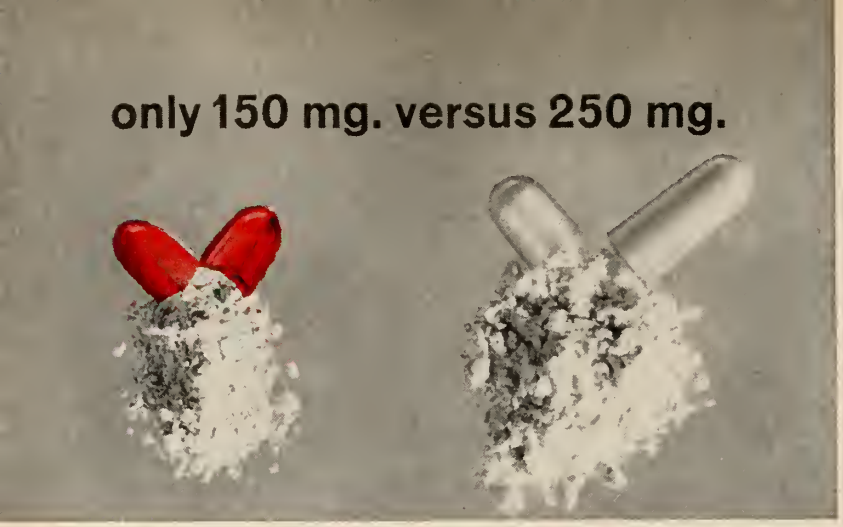
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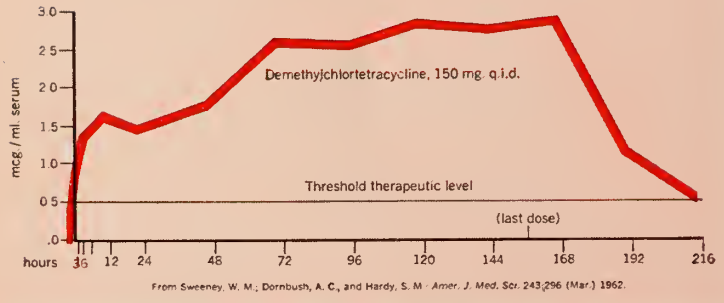
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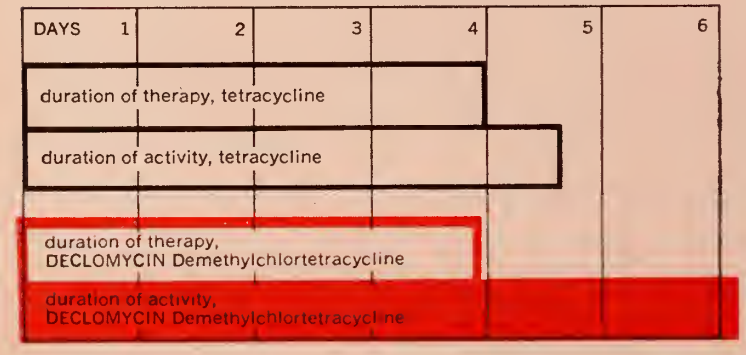


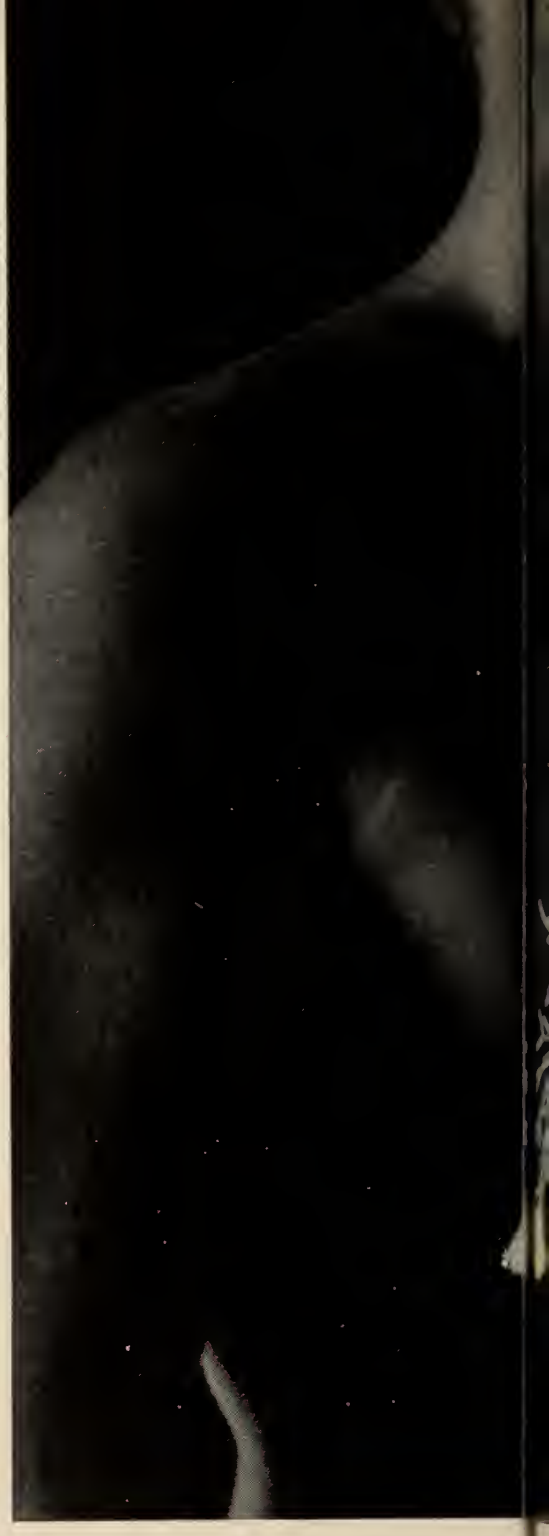
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From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

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*Clinical report on file, Medical Department, A. H. Robins Co., Inc.

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289 Michigan Students Enter Two Medical Schools

A total of 289 Michigan students are among the 328 incoming first-year medical students selected by the University of Michigan and Wayne State University for this coming fall. Michigan selected 174 state residents while Wayne chose 115 from Michigan cities.

Of the 39 non-Michigan residents admitted, two are from foreign countries.

A study of the reports from the two Schools of Medicine reveals that 99 of the 203 admitted at Ann Arbor are from the University of Michigan; while 43 of the 125 at Wayne are from Wayne State University.

Both medical schools reported an increase in applications. The University of Michigan chose the 203 from 1,140 applicants, while Wayne had 700 applicants.

U-M DETAILS

Other Michigan schools contributed students to the U-M Medical School as follows: Wayne State University 7; Michigan State University 17; University of Detroit 2; Eastern Michigan University 2; Western Michigan University 4; Albion 5; Hope 7; Calvin 6; Northern Michigan 1; Alma 2; Kalamazoo 3; Michigan College of Mining and Technology 2; General Motors Institute 1; Aquinas 1; Hillsdale 1. Two are from foreign countries.

WSU DETAILS

Twenty-five of the 125 will enter the School of Medicine under its 2-4-2 Program. Under this program the first two years of a student's college education are spent at any accredited college of liberal arts and are directed at completion of both liberal arts college and pre-medical requirements. The next four years are divided between the Wayne State University College of Liberal Arts and the School of Medicine and are devoted to an integrated program of study leading to the bachelor's degree and completion of basic medical sciences. The final two years of medical training are spent in clinical training at the School of Medicine and in its affiliated hospitals and clinics.

Students coming from other Michigan schools are: University of Detroit 7; Michigan State University 5; Albion College 6; University of Michigan 21; Hope College 4; Kalamazoo College 4; Western Michigan University 2; Eastern Michigan University 2; Calvin College 2; Central Michigan University 1.

Michigan Women to Hear National Auxiliary President

For the first time in several years, the president of the Woman's Auxiliary to the AMA will speak at the annual convention of the Michigan Auxiliary.



The convention program for the Woman's Auxiliary to MSMS will offer Mrs. William H. Evans as a speaker, Wednesday afternoon, Sept. 23. The Auxiliary will hold its annual convention at the Pick-Fort Shelby Hotel, Detroit, September 22-24. Mrs. Evans will come here from Youngstown, Ohio, where her husband is an Ophthalmologist and Otolaryngologist. A past president of the Ohio Auxiliary, she has been a chairman or officer on the national level since 1957.

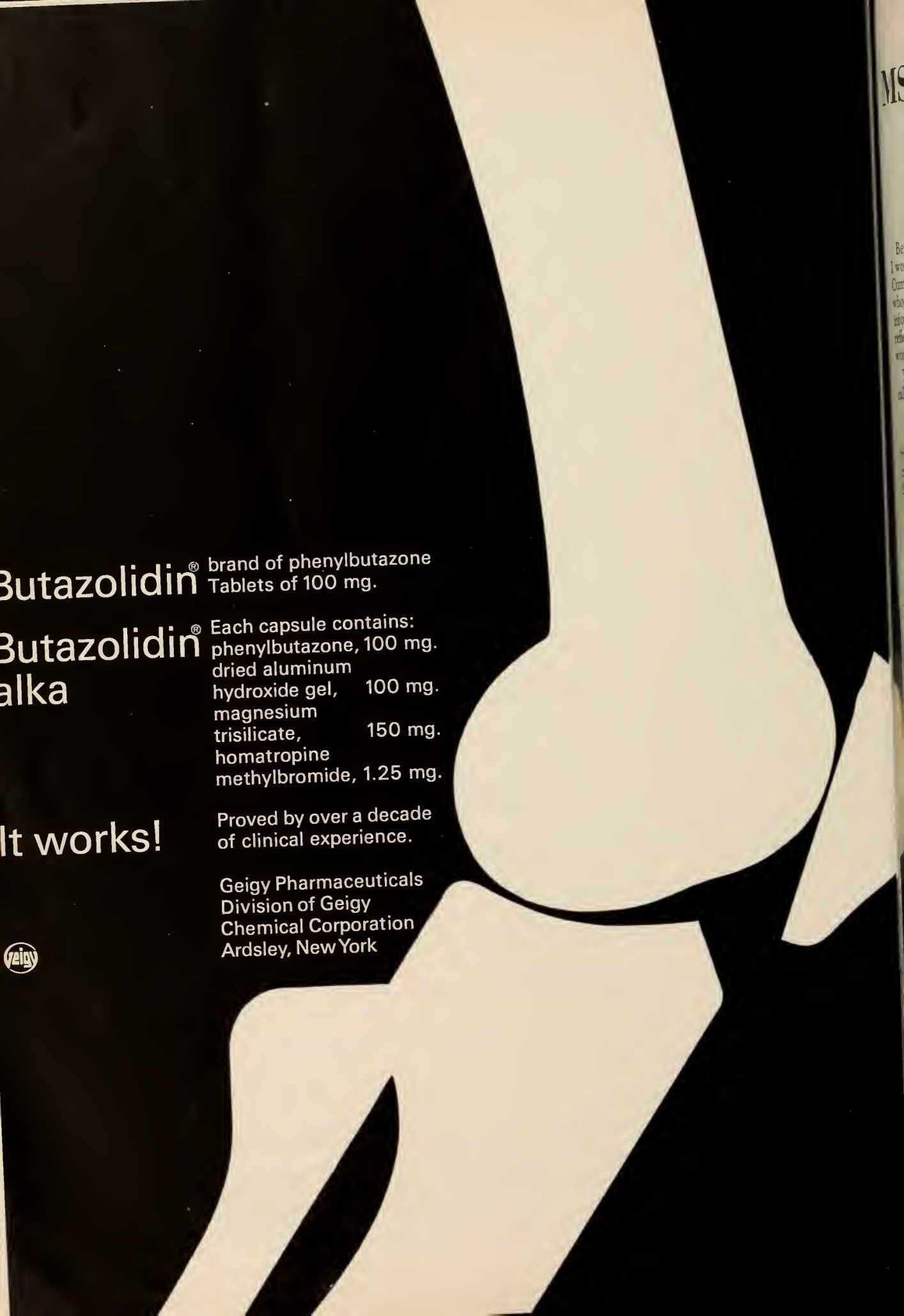
Rev. McCleave Coming To MSMAS Convention

Rev. Dr. Paul B. McCleave, director of the new AMA Program in Religion and Medicine, will speak at the Annual Convention of the Michigan State Medical Assistants Society in Detroit, September 23-24. Rev. McCleave spoke to the MSMS County Secretaries-Public Relations Seminar in February and has met with the new MSMS Committee on Religion and Medicine.

All medical assistants—whether they are members of MSMAS or not—are invited by Mrs. Dorothy M. Brandis, President, to attend the convention at the Statler-Hilton Hotel.



ANCILLARY SECTION


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MSMS Centennial Series: 1943, 1944

Michigan Health Council Is Organized

1943

Before taking up the wartime events of 1943, I would like to put down something about Doctor Cummings. He was one of the few Past Presidents who answered the questionnaire sent to them for information for this historic series. I think his reply reflects the character of the man himself and his work during his administration.

The question was, "What were the notable medical events during your term?"

Here is his answer:

"Postgraduate Conference on War Medicine; Spring and Fall teaching centers conducted in five centers in the Northern Peninsula; Protection of the health interests of the people of Michigan with one-third of our doctors in Service and the Government attempting to care for the wives and families of soldiers, obstetrical care and pediatrics with compensation to the doctors without consulting the medical profession. Establishment of Foundation for the advancement of Medical Education in Michigan.

"I take no credit for the activities advanced by the Michigan State Medical Society during this war period. I only am grateful that it was my privilege to serve the physicians of Michigan, the government of my country and the people of the State of Michigan."—H. H. Cummings, M.D.

A fine record I think.

° ° °

MILITARY POSTGRADUATE courses were started in 10 medical schools including the University of Michigan. A large number of doctors were sent to postgraduate studies for a few weeks before going into service.

The Annual Meeting of The Council was held in Detroit on January 16 and 17, 1943. The following were the highlights:

1. Membership of the MSMS at an all time high was 4,714.
2. 1,500 Michigan doctors were serving in the Armed Forces.
3. Industrial Medical and Surgical Clinic, April 8 in Detroit, approved.
4. Study of post-war postgraduate programs and special medical refresher courses recommended.
5. Integration of all medical postgraduate programs in Michigan recommended.
6. Proposed amendment to the Michigan Medical Practice Act, to permit licensing of graduates of wartime telescoped medical courses approved.

The Survey of Medical Service Available for Civilians conducted through County Medical Society Secretaries in January found 18 secretaries reported critical shortages of doctors in certain areas; and 10 secretaries reported abnormal increases in population and the need to relocate 66 physicians.

° ° °

RESTORATION OF THE historic early house on Mackinac Island as a memorial to William Beaumont, M.D., was assured when the ownership of the property passed from private hands to the Mackinac Island State Park Commission. Purchase of the Early House had long been a project of both the Mackinac Island State Park Commission and the MSMS. Completion of the purchase was accomplished in November.

Unprecedented in the history of Michigan was the joint meeting of the executives of the MSMS and the Michigan Hospital Association held on July 17. An important program of joint activity and endeavor, to which officers of Michigan Hospital Service and Michigan Medical Service also subscribed, were outlined by spokesmen and referred to a joint committee as a result of this meeting.

MSMS vigorously opposed the Wagner-Murray Bill, which called for one man to direct the nation's medical care. He would be given 3 billion dollars initially to implement the scheme. This would be complete socialization.

The 78th Annual Meeting of the MSMS called a Postgraduate Conference on War Medicine was held in Detroit, September 22-24. Twenty-two out-of-state guest essayists were present.

The Board of Supervisors of Wayne County es-



The Author
WILLIAM J. STAPLETON, JR., M.D.
MSMS Historian

Leading up to the MSMS Centennial in 1965, THE JOURNAL *is printing a series of articles by William J. Stapleton, Jr., M.D, Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* THE JOURNAL *and will continue through August, 1965.*



H. H. Cummings, M.D.
MSMS President, 1942-43



C. R. Keyport, M.D.
MSMS President, 1943-44

tablished a full-time County Health Department, May 1, 1943. This was the 69th county to provide this service.

The Barbituric Control Bill experienced a stormy time in the 1943 Michigan Legislature. The controversy centered around the word administration—the House refused to include the word and the Senate would not pass the bill without the word. Finally, the Conference voted to include the word.

* * *

THE MSMS AND THE State Bar of Michigan united in a campaign against venereal disease. Representatives of both these professional organizations met May 23 and appointed a joint committee to devise ways and means to control venereal diseases by education, by legislation, and by increasing necessary hospital facilities.

The Council held a conference with representatives of the Bureau of Maternal and Child Health of the State Department of Health and discussed the federal program of rendering aid to the wives of men in service. The Council took the following stand: that the MSMS should co-operate in a plan provided (1) that the program terminate 6 months after the end of the present war, (2) that the physician-patient relationship on a fee basis be maintained, and (3) that the forms be simplified. The Council disapproved the features of the present plan which placed a bureaucrat between the patient and her doctor.

1944

As of April, there were 2,175 Michigan doctors in the Armed Forces of the United States. This shows that Michigan doctors were doing their share of work.

Among the matters of interest during the year was the special assessment for 1944 for educational purposes, which was levied by the Michigan State Medical Society House of Delegates the previous September. Membership cards were issued only upon payment of $22 to the State Society, representing the regular dues and the special assessment.

The mid-winter meeting of The Council was held in Ann Arbor. The following was a digest of their action:

1. Membership of the MSMS was at an all time high—4,786.

2. Psychiatric Clinic in connection with the Wayne State University School of Medicine discussed.

3. Second Annual Postgraduate Industrial Medical and Surgical Conference was scheduled for April 6 in Detroit.

* * *

ACTING UPON instructions of the 1943 House of Delegates, The Council endeavored to obtain certain modifications of the bureaucratic orders governing the distribution of care under the Emergency Maternity and Infant Care Program. Negotiations had been in progress since May 22, 1943. The Executive Committee reported in February that no agreement could be made.

Departing from traditional standards so "the general public may have a more intimate knowledge of the great contributions and tireless efforts of the doctors who serve them," MSMS entered the field of promotion via radio. Stressing the importance of maintaining the private practice of medicine and of increasing the use of prepayment medical and hospital plans, the Society sponsored a series of thirteen weekly programs on 12 stations.

The Michigan Physicians Committee, a branch of the National Physicians Committee, was organized at a meeting held in Detroit on October 11. Representatives from the MSMS Councilor Districts were present at the meeting. The Michigan Physicians Committee will work in the interest of better medicine, the preservation of all that is valuable in the present American type of private practice, together with the encouragement of supplemental features, where needed, to the end that good medical care is distributed to all in the State who need it.

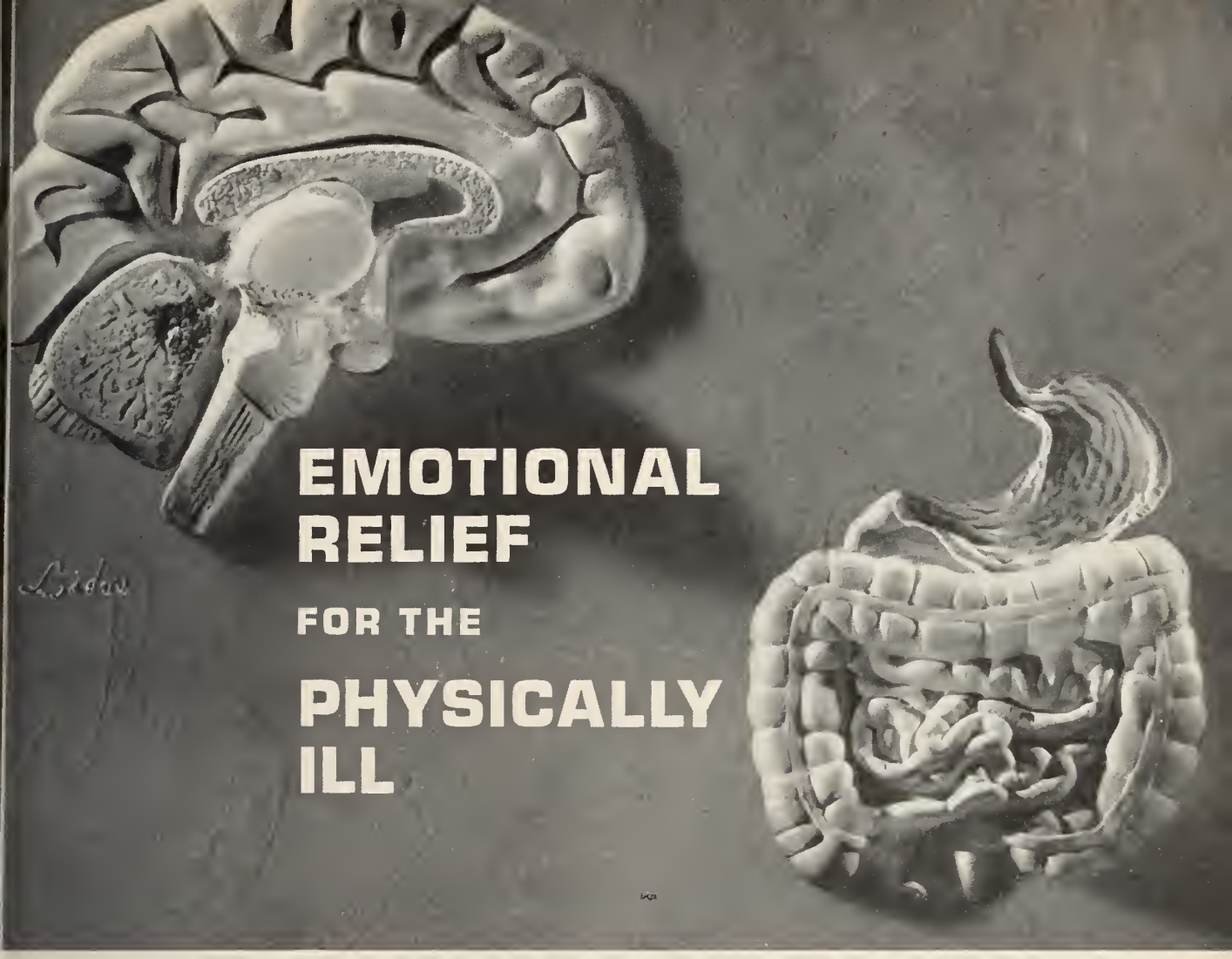
The Michigan State Board of Registration in Medicine took action effective January 1, 1944, to reduce temporarily, as a war measure, the 12 months of rotating internship to nine months in an approved U. S. hospital.

The Executive Board of the Woman's Auxiliary to the MSMS held its 18th mid-year meeting in Detroit, to advance two projects: the defeat of the pending Wagner-Murray-Dingell Bill, and the campaign to recruit girls for the nursing profession.

* * *

THE IDEA OF forming a health council was advanced at a meeting July 16-17, 1943, at Mackinac Island. This meeting was attended by members of The MSMS Council and representatives of the Michigan Hospital Service. The Michigan Health Council was incorporated as a non-profit organization in 1944.

A Medical Veterans Readjustment Program to aid returning medical officers of Michigan was created by the 1944 House of Delegates in Grand Rapids. The program sought to assist medical officers with problems of relocation, finances, and postgraduate work. The House of Delegates instructed that an assessment of $5 be levied in 1945 on every active member to defray the expenses of this post-war veteran's program.



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Say you saw it in Michigan Medicine

One of the advantages of membership in the Michigan State Medical Society is its ever-improving program of group insurance. MSMS Research Director, Mr. Richard M. Campau, who is also staff assistant to the MSMS Committee on Professional Insurance, has interviewed the MSMS Insurance Administrator Ben P. Stratton, of Lansing, Michigan. Some of the questions raised and the answers are listed below:

"What Is Unique About MSMS Insurance Program?"

Why should a professional association sponsor a group insurance program for its members?

This question can best be answered in two parts. First, the self-employed professional person does not have available the generous fringe benefits enjoyed by most employed persons. Association group insurance helps to partially overcome this inequity. Secondly, the very nature of group insurance makes it attractive to most members. Here are some of the advantages of group insurance over individually sold policies:

1. The cost is lower because the carrier's selling and administrative costs are lower.
2. Benefits are usually as broad and perhaps broader than those of individual policies.
3. It is easy to apply. Applications are brief. Medical examinations usually aren't required. In many cases persons may obtain insurance when they would be ineligible for individual policies for physical reasons.

Does group insurance interfere with an individual's personal program?

On the contrary, group insurance aids in carrying out the objectives of a sound personal insurance program. It should be remembered, however, that group insurance should not be called upon to do the entire job. The need still exists for a competent insurance representative often working with the member's attorney or accountant.

What types of association group insurance are available?

1. Disability Income.
2. Life Insurance. Both group term and group permanent are available. Dependents may also be added.
3. Business Overhead Expense. This is designed to pay fixed overhead expenses that continue even though the insured person is disabled.
4. Accidental Death and Dismemberment. This policy provides high limits of indemnity for loss of life or members. Spouses may also be covered.
5. Professional Liability. While this type of insurance is not generally available through an association sponsored plan, there is a growing trend toward including this as one of the basic types of insurance to be offered.

Does group insurance add to an association's expenses?

Generally the administrative costs of a group program are borne by the program itself. In other words, premiums paid by individual members contain an expense loading. If some additional administration is placed on the association, the effort is well expended because the members gain greatly from a comprehensive and sound group insurance program.

Would you please briefly describe the MSMS Group Insurance Program, particularly some of its unique features?

MSMS now has the following group plans in effect:

1. *Disability Income.* This was inaugurated in 1955. The carrier is Provident Life and Accident insurance Company. In 1963 the plan was improved by extending illness benefits from two to five years. The plan is now being further improved to allow members to apply for higher limits of indemnity and to apply for a plan providing illness benefits to age 65.
2. *Life Insurance.* Group term and group permanent life insurance is available through a



plan with Mutual Benefit Life Insurance Company of Newark, New Jersey. This plan has been in effect since 1959.

3. *Other Plans* are in various stages of approval and consideration and information regarding such plans may become available in the near future.

Would you please describe in detail this year's improvements in the MSMS Disability Income Insurance Program?

The program has been improved in the following ways:

1. Benefits for total disability resulting from accident were extended from five years to lifetime for disabilities commencing prior to age 66.
2. Benefits for total disability resulting from sickness were extended from two years to five years for disabilities commencing prior to age 66.
3. Weekly indemnity amounts were changed to monthly indemnity as follows: $50 weekly changed to $215 monthly. $75 weekly changed to $325 monthly.
4. The Waiver of Premium provision was changed to cover entire period of continued disability even if this extends beyond the period of compensable disability.
5. Air travel restrictions were eliminated except for accidental loss of life or members. These restrictions were also liberalized for accidental loss of life or members.
6. Partial disability for sickness was liberalized. This was formerly only payable after payment of benefits for total disability from sickness for at least 30 days. This is now payable after period of total disability from sickness for 7 days or more.
7. New optional benefits are also available. Sickness disability benefits may be extended to those who are eligible from five years to age 65. Also monthly indemnity may be increased for those eligible to $400 or $500.

How many MSMS members participate in the various insurance plans?

In answering this it must be remembered that the largest county society (Wayne) has a complete insurance program available for its own members. The MSMS Disability Income Plan is available to all eligible members including Wayne County Medical Society members and more than 2000 are insured.

The Group Life Insurance Plan is available to all members except members of Wayne County Medical Society and over 1500 are insured. As previously mentioned other plans are in the planning stage.

in the overweight stable adult

...fasting serum levels of insulin are usually normal, postprandial levels excessive[1-3]

...insulin acts in adipose tissue via hexose monophosphate shunt, principal path of glucose conversion to storage fat[1,4]

...excessive endogenous insulin acts to stimulate lipogenesis and weight gain[1,3,4]



Osteopathy in Michigan

The MSMS Economic Department has recently compiled information regarding frequently asked questions on Osteopathy in Michigan. Sources for this information include the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons, Inc.

How many D.O.'s in Michigan?
Answer: 1825

How many D.O. Specialists?
Answer: Approximately 258 (All figures listed below are approximates.)

- Radiology — 36
- Orthopaedic Surgery — 5
- Internal Medicine — 20
- Obstetrics-Gynecology — 38
- Obstetrics-Gynecology-Surgery — 11
- Proctology — 15
- Physical Medicine — 6
- Otolaryngology — 17
- Pathology — 12
- Surgery — 68
- Dermatology — 5
- Anesthesiology — 25

How many D.O. Hospitals in Michigan? D.O. Beds?*
Answer: 38 D. O. Hospitals with 3,600 beds

How many joint M.D.-D.O. hospitals? Beds?
Answer: 13 hospitals with 1,137 beds:

- Hayes Green Beech Hospital, Charlotte (65 beds)
- Mason General Hospital, Mason (49 beds)
- McPherson Community Hospital, Howell (75 beds)
- Lapeer County General Hospital, Lapeer (134 beds)
- Gratiot Community Hospital, Alma (119 beds)
- Seaway Hospital, Trenton (86 beds)
- Annapolis Hospital, Wayne (150 beds)
- Outer Drive Hospital, Lincoln Park (150 beds)
- Beyer Memorial Hospital, Ypsilanti (154 beds)
- Anderson Memorial Hospital, Harrison Township (100 beds)
- Harbor Beach Community Hospital, Harbor Beach (15 beds)
- St. Ignace General Hospital, St. Ignace (20 beds)
- Mecosta General Hospital, Stanwood (20 beds)
- (There may be new ones not yet reported)

*This compares to 182 MD short term general hospitals with 26,407 beds.

diabetic

...DBI lowers high blood sugars without promoting fat synthesis, encourages gradual weight loss[2-9]



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side effects: Gastrointestinal, occurring more often at higher dosage levels, abate promptly upon dosage reduction or temporary withdrawal. **precautions:** Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in non-diabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B. U. N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **pregnancy warning:** *During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided.* Consult product brochure for full information.

1. Gordon, E.S.: Metabolism 11:819, 1962. 2. Grodsky, G.M. et al.: Metabolism 12:278, 1963. 3. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 4. Sadow, H.S.: Metabolism 12:333, 1963. 5. Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. 6. Faludi, G.: Geriatrics 18:452, 1963. 7. Williams, R.H.: Textbook of Endocrinology, Ed. 3, Saunders, Phila., 1962, p. 610. 8. Weller, C. and Linder, M.: Am. Therap. Soc., June 1963. 9. Moss, J.M. et al.: Med. Times, July 1964.

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State Is Part of National Blue Shield Survey

Michigan doctors are among those being surveyed now as part of the Nation-wide Blue Shield Test of Performance Survey. The study will assess the extent to which Blue Shield fees are covering doctors' charges.

Pilot surveys in Alabama and Massachusetts produced a 90 per cent return.

A random sampling of recently paid claims is made, and the doctor is sent a questionnaire dealing with that case. Answering a questionnaire requires about one minute, through use of check-off boxes. Completed questionnaires are returned to National Association of Blue Shield Plans in a postage-paid envelope that is provided. The information provided by physicians is completely confidential; the portion of the questionnaire which identifies the doctor and the patient is torn off by the doctor before he returns the questionnaire.

The questionnaire refers to a specific case recently paid by Blue Shield, and asks the doctor: If he accepted the Blue Shield payment as payment in full for the services covered by Blue Shield; if not, what his total fee was, and the reason that the Blue Shield fee was inadequate; what his normal fee to the patient would have been in the absence of Blue Shield coverage, and two questions about his years in practice and nature of practice.

Consumer Price Index Increases in Detroit

The Detroit Consumer Price Index increased 0.4 per cent from May to June, according to a report issued by John W. Lehman, Director, East Central Regional Office, U. S. Department of Labor's Bureau of Labor Statistics. The new series June index for Detroit is 103.6 (1957-59=100): 0.1 per cent above the level of a year ago.

Increases of 1.2 per cent for transportation, 0.8 per cent for food and 0.3 per cent for housing were recorded in Detroit by the Bureau of Labor Statistics from May to June. Over the same period, the index for apparel and upkeep decreased 0.1 per cent and the index for health and recreation was unchanged.

Compared with a year ago, increases of 1.7 per cent for apparel and upkeep, 0.4 per cent for health and recreation and 0.2 per cent for housing have occurred. Over the same June, 1963 to June, 1964 period, decreases of 0.2 per cent for food and 0.1 per cent for transportation have been recorded.

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What Cities Attract Michigan Interns?

Following is a composite chart showing which cities were selected by 1964 Medical School graduates for internships:

City	Wayne State University	University of Michigan
Ann Arbor	1	18
Dearborn	3	1
Detroit	35	12
Eloise	2	8
Flint	2	—
Grand Rapids	3	9
Grosse Pointe	3	1
Highland Park	1	—
Kalamazoo	3	13
Lansing	—	2
Midland	—	3
Muskegon	2	—
Pontiac	10	1
Royal Oak	2	1
Saginaw	—	9
Traverse City	—	6

Heads Nursing School

Gwendoline R. MacDonald, Ph.D., formerly with the National League for Nursing, is the new director of the School of Nursing at Michigan State University. She succeeds Florence C. Kempf, who retired July 31.

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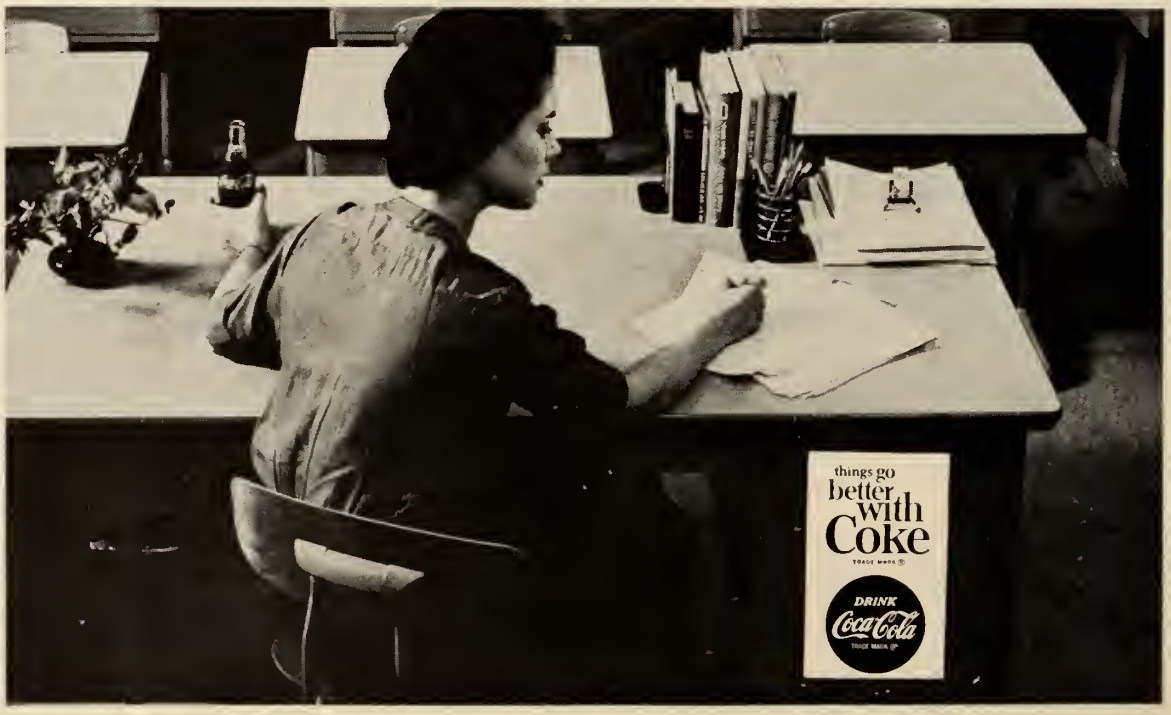
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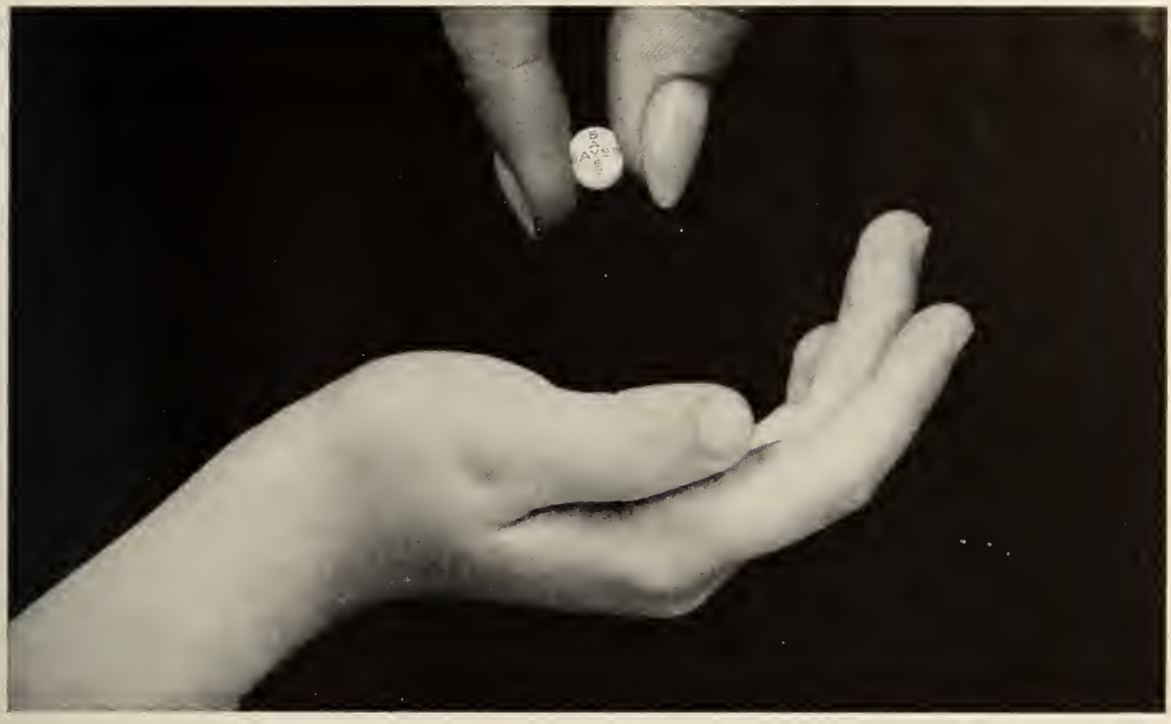
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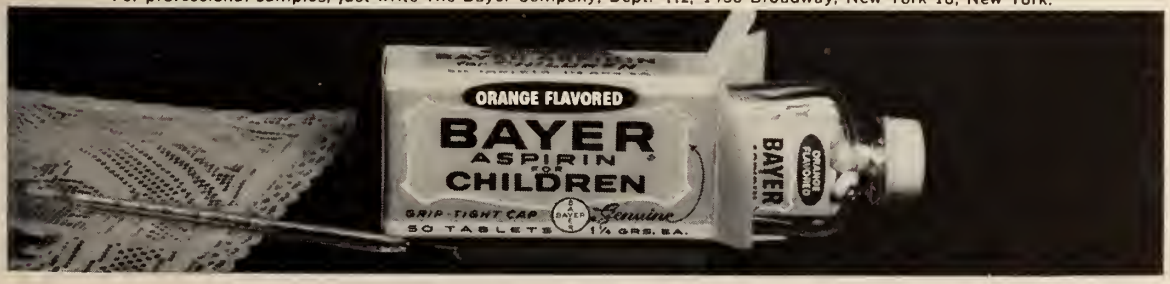


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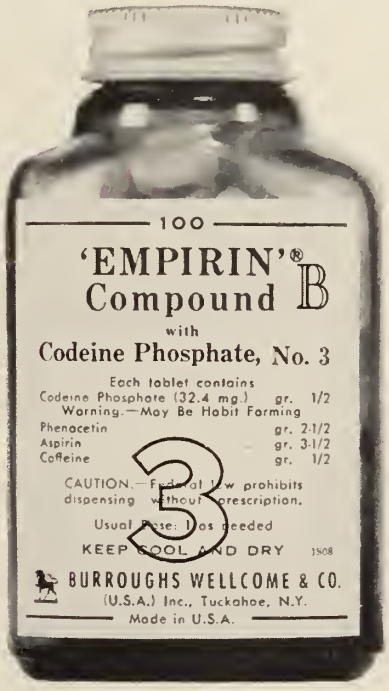
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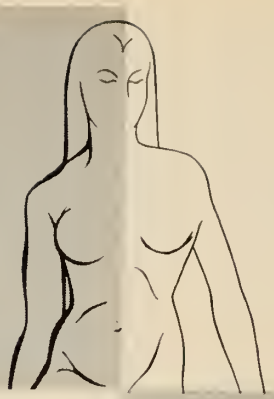
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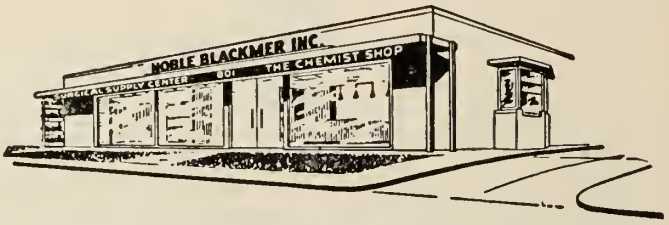
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1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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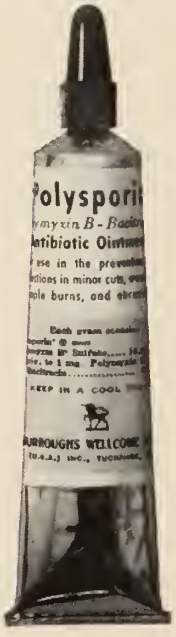
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President's Message

The Election and The Doctor

By OLIVER B. McGILLICUDDY, M.D.
MSMS President

November third and the election are about a month away.

How will you feel on November fourth?

On that day your choice of candidates may have won or lost. Either way you will, I am sure, ask yourself if you did your part as a good citizen.

Surely you voted? In the past, some doctors have said they were too busy to vote. Did the eligible members of your family vote? Did you make sure that your office assistants voted? The doctor with the most personal satisfaction on that day after the election will be the one whose candidates won, especially if the doctor was part of the team. As a member of the team, he probably didn't ring doorbells but he displayed campaign literature in his office and he talked with some of his patients about his candidates. He only talked with some of his patients; no one expects the professional man to try to convert every person he sees.



He certainly gave generously to the campaign funds of his candidates. He either did this by a check to his county, state or national political party or better still to the candidates directly.

Lastly, the doctors with the most satisfaction on November 4 will be those who gave to the American Political Action Committee, AMPAC, and our own Michigan counterpart, MD-PAC. These groups will actively support friends of medicine in both parties.

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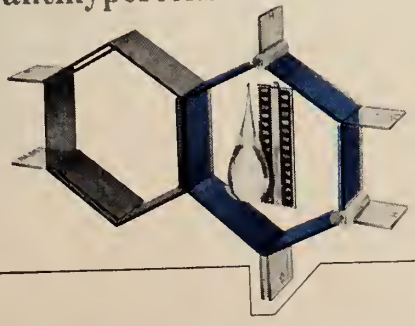
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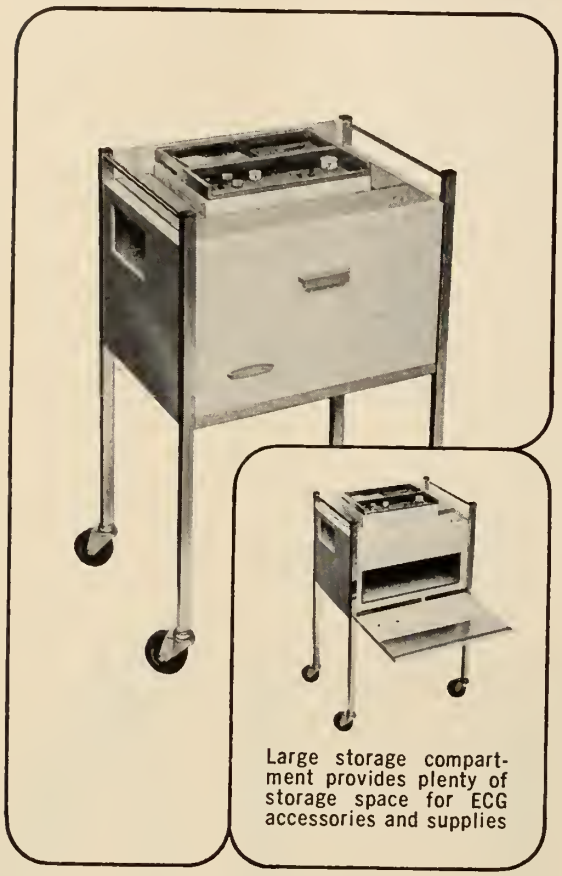
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NEWS BRIEFS

An interesting feature story in *The Flint Journal* reports that in Flint there are 88 medical externs, interns and residents—but only 28 of them are from the USA. Sixty of these medical students at Hurley, St. Joseph and McLaren General Hospitals are from other countries—with 13 from the Philippines leading the list. Three of 88 are from Flint.

R. W. Teed, M.D., Ann Arbor, represented MSMS officially at the National Voluntary Health Conference sponsored by the AMA in Chicago, September 17-18.

Past president of the Oceana County Medical Society, **Clarence Diehl, M.D.,** Shelby, has moved to King City, California, to practice there.

One of the divisional leaders in the Battle Creek area United Fund campaign is **Jack Campbell, M.D.**

There's another father-son combination in Michigan—**Robert Willis Oakes, M.D.,** has entered practice with his father **Charles Willis Oakes, M.D.,** Harber Beach. A graduate of the University of Michigan, Robert interned at Toledo, served as a flight surgeon in the Air Force and then did a general-practice residency at Toledo.

An interesting feature story in the *Jackson Citizen-Patriot* described the skeet-shooting abilities of **E. F. Lewis, M.D.,** and his overall interest in physical fitness.

Joseph G. Gough, M.D., former resident in physical medicine at the University of Michigan, has joined the staff of the American Legion Hospital, Battle Creek, as director of physical medicine and rehabilitation.

Kenneth A. Kooi, M.D., Ann Arbor, is busy as secretary of the American Electroencephalographic Society helping with plans for the Society's annual meeting in October at Bishop's Lodge at Sante Fe, New Mexico.

Wm. H. Shock, M.D., Saugatuck, has been appointed to fill a vacancy on the Saugatuck Board of Education.

Grant L. Otis, M.D., Jackson, Chairman of MSMS Disaster Medical Care Committee, attended a two-day AMA Conference at Louisville on what action doctors should take in the event of disaster.

Kermit Ericcson, M.D., former intern at Grand Rapids Blodgett Hospital who practiced in Reed City during the summer, will serve five years as a Medical Missionary in Ethiopia.

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The Role of Alcohol In Fatal Traffic 'Accidents' And Measures

NEEDED TO SOLVE THE PROBLEM

By HORACE E. CAMPBELL, M.D.
Denver, Colorado

This paper was presented September 24, 1964
at the MSMS Annual Scientific Session in Detroit

It has been known for years that the drinking driver was responsible for many traffic "accidents", if we may call them accidents.

Recently, the motorboat has begun to displace the automobile as a status symbol, and the drinking driver of motorboats is becoming a problem.

Further, incredible as it may seem, the drinking small-plane pilot is appearing as an increasing cause of air crashes. Excluding crop control flying, in the United States in 1959, there were 378 fatal small-plane crashes, with intoxication as a factor in seven; in 1960 there were 373 fatal small-plane crashes, with intoxication as a factor in 15, and in 1961, 366 fatal crashes with 10 intoxication cases.[4]

Earlier data, based upon court convictions,[1] have been found unreliable as a guide to the extent of the drinking driver problem.[5] In a collected series of 2,795 fatally injured drivers tested chemically for alcohol, 61 per cent had been drinking; and based on 2,307 of these fatalities in which the figures were complete, 58 per cent had blood alcohol levels at 0.05 per cent or above, the level below which impairment is thought not to occur (Table I).

Since this table was compiled, additional studies have been completed. Coroner's records in seven large California counties for 1961 revealed that 55 per cent of the drivers dying within eight hours of their accidents had blood-alcohol ratios of 0.10 per cent or higher.[12] Sixty-eight per cent of 291 fatally injured drivers had been drinking.

A more detailed study carried out in 1962 in eight large counties which comprise 69.4 per cent of the total population of California, and embrace 67.8 per cent of the state's registered motor vehicles, concerns 648 fatally injured drivers who died within six hours of their crash. Of these, 633 (97.6 per cent) were tested for alcohol, and 54 per cent had been drinking.[12]

More drivers were killed in single-vehicle crashes than in any other type—266 cases. Sixty-seven per cent had been drinking with 59 per cent having blood-alcohols of 0.10 per cent or higher. Thirty other drivers hit parked cars. More than 63 per cent of this group had been drinking—all of whom had blood-alcohol ratios of 0.10 per cent or higher.



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LARGEST OF ALL FACTORS

These data all combine to prove that the drinking driver is involved in well over half of all the fatal accidents, and therefore as a factor looms larger than all the other factors, e.g., bad roads, faulty maintenance of vehicle repair, bad weather,

TABLE I. THE ROLE OF ALCOHOL IN FATAL TRAFFIC "ACCIDENTS"

Reference No.	Region Reported	Data for Years	Fatal Accidents	Driver Fatalities	Drinking Drivers Per Cent	Blood Alcohol over 0.15%	Blood Alcohol over 0.10%	Blood Alcohol 0.05-0.15%	Blood Alcohol 0.01-0.04%
1	N.Y. City	1928-1937		215	60		50%		
2		1957		69	55		55%		
3		1959-1960		34+	59		50%		
4	Westchester County	1950-1957		83*	73	49%	56%	20%	4%
5	Cleveland	1937-1955		885	54	40%		12%	2%
6	Montana	1956		134	55				
7	Maricopa Co. Ariz.	Jan.-June 1958	60**		47				
8	Delaware	1955	97		57				
9	Delaware	1956	75 58**		51 65	33%++ 43%++			
10	Maryland including Baltimore	1950-1959		983	69	40%		22%	6%
11	Baltimore	1951-1956		156	62	37%		21%	4%
12	Middlesex Co., N.J.	1948-1959		264	50	17%		33%	
13	State of New York	1959		92#	87	51%	75%	33%	3%
14	State of Conn.	1959		36#	67				

+Dying within six hours of the crash
*Single-vehicle accidents, with death within 4 hours
**Pedestrian fatalities eliminated
++62 per cent of the drinking drivers had blood alcohol readings over 0.15%
#One-car fatal accidents, with death within 24 hours

TABLE II. INCIDENCE OF DRINKING AMONG THE GENERAL DRIVING POPULATION

Author	City	Number Tested	No. HBD	%HBD	Alcoho 100-150 mg. %	Alcohol 150 mg. & over
Holcomb	Evanston	1,750	212	12%	1.49%	0.42%
Lucas et al.[10]	Toronto	2,015	176	8.7%	1.9%	1.4%
Forrester[7]	Buffalo	125	16	12.8%	6.4%	1.6%
McCarroll & Haddon[11]	New York	217	52	26%	(100 & over) 4.0%	
Borkenstein[3]	Grand Rapids	7,590	834	11%	0.58%	0.18%
TOTALS		11,697	1,290	11%+		

N.B. In the figures from Toronto and Buffalo, persons with blood alcohol levels under 50 mg.% were not considered as having been drinking. In the others, 10 mg.% was considered positive, and placed the driver in the HBD group.

all these combined. As such, the problem of the drinking driver should get the attention that it deserves.

But several prominent people, doctors, lawyers, social scientists, and legislators, in particular, all of whom ought to know better, insist that these figures do not mean a thing. They say that at least three out of four drivers drink and drive, and since only fifty per cent or so of the fatally injured drivers have been drinking, the alcohol is obviously a protection.

Table II reveals the fallacy of this type of thinking.

By testing drivers in the non-accident driving population either at the scene of an accident, or at the site on the same day of the week and at the same hour, it becomes obvious that on the average, the week around, and the clock around, about 11 per cent of the driving population has measurable amounts of alcohol in the breath or blood.

Hence it appears that 12 per cent of the drivers account for 60 per cent of the fatal accidents, and 88 per cent of the drivers account for the remaining 40 per cent. The drinking drivers are subject to the basic driving risk, too, of course. This can be calculated as 12/88 of 40 per cent or nearly 6 per cent. It may be concluded then, that the alcohol is the factor *responsible* for the deaths of 54 per cent of the fatally injured drivers.

Realistically, the picture is even blacker than this. Those who study fatal accident records find that again and again the drinking driver responsible for the accident escapes with little or no in-

jury. On the other hand, in studying the records of 422 fatal accidents occuring in Colorado during 1963, there was only one case in which the obverse was true. This driver, with a blood alcohol of 213 mg. per 100 ml. of blood, was driving along on his side of the road minding his own business when an on-coming driver, who proved to have had a completely clean driving record, crossed the center line, and killed the competent drinker, having no alcohol in his own blood, and escaping with minor injuries.

But more than this, it is well known that in fatal crashes with two or more persons in the car, the driver is sometimes the only survivor, probably because the steering wheel, up to a point, provides the driver some protection. Thus these crashes would not have entered our tabulation of driver fatalities.

SERIOUS ATTENTION DEMANDED

We conclude again: the drinking driver is the largest part of our traffic death and serious injury problem. We must give him the serious and scientific study that he requires.

Norway was the first nation to attack the matter realistically. In 1926, enough scientific information was available that Norway made it illegal for anyone to drive or to attempt to drive a motor vehicle if the blood alcohol was "in excess of 0.05 per cent (by weight)". This is two drinks on an empty stomach for a 150 pound person.

A driver with this amount of alcohol has an excellent chance of spending at least 21 days in jail in Norway. In only the rarest exceptions does he escape a jail sentence. If he is standing anywhere near a motorcar, he is likely to be arrested. He can reduce his sentence to seven days by going on bread and water. Max Eastman writes, "One's convivial friends, they tell you in Oslo, disappear from time to time and come back in a week describing a wonderful vacation in the Canary Islands but looking suspiciously thin".

Sweden adopted rather similar legislation soon after, used 0.08 per cent for some twenty years, but in 1959 reduced the figure to 0.05 per cent. Under the influence of this legislation these countries have developed a cultural pattern in regard to drinking and driving which we will discuss at a later point.

In the United States, a Committee of the American Medical Association, alarmed by the distressing increase in alcohol-related deaths and injuries following Repeal, set out to formulate a definition of "under the influence". The net result of this effort has been that the level of 0.15 per cent has become the dividing line between "sober" and "under the influence".

This means at least eight standard drinks for a 200 pound person on an empty stomach in somewhat less than an hour, and six drinks for a 140 pound person in somewhat less than two hours (Table III). This is one of the obvious reasons why 60 per cent of the fatal crashes in this country involve drinking drivers.

All the authoritative organizations here are now recommending that the *prima facie* level of intoxication be reduced to 0.10 per cent (100 mg. per 100 ml. of blood). New York, North Dakota, and North Carolina are the only States to have adopted this type of legislation.

At a level of 0.10 per cent (four drinks for the 140 pound person, and six for the 200 pounder) it is agreed by the scientific authorities that everyone suffers impaired driving ability.

If the object is to prevent motorcar crashes, the legal level will have eventually to be brought to that level at which most people do not demonstrate impaired driving ability, i.e., at least to the level of 50 mg. per 100 ml. of blood, a point which the realistic Norwegians accepted almost 40 years ago.[2]

Forney *et al*[6] found that five out of 25 drivers were impaired in a sports car event at blood alco-

TABLE III. CHART RELATING per cent ALCOHOL IN THE BLOOD TO BODY WEIGHT AND NUMBER OF DRINKS

(Subtract 0.015% for each hour from the time drinking started)

No. of Drinks	1	2	3	4	5	6	7	8	9	10
Body Weight in lbs.										
100	.042	.084	.127	.170	.212	.255	.295	.34	.38	.42
120	.035	.070	.106	.142	.176	.213	.248	.28	.33	.35
140	.029	.059	.090	.121	.152	.180	.212	.24	.27	.30
160	.025	.052	.078	.106	.132	.160	.185	.21	.24	.26
180	.023	.046	.069	.093	.118	.140	.164	.19	.21	.23
200	.021	.042	.062	.084	.105	.126	.148	.17	.19	.21
220	.019	.038	.056	.076	.096	.115	.133	.15	.17	.19
240	.017	.034	.052	.070	.088	.105	.123	.14	.16	.17

Tabulation derived from the ALCODIAL, Dr. R. G. Bell and Dr. J. K. W. Ferguson, and reproduced with permission from DRINKING AND DRIVING H. Ward Smith, Ph.D., Director, Attorney-General's Laboratory, Toronto, Criminal Law Quarterly, Vol. 3, No. 1 (May) 1960, Canada Law Book Co. Ltd. 76 Pearl St., Toronto, Ont.

hol levels of 50 mg. per cent. Facts like these have already been recognized in Norway and a movement is afoot there to reduce the statutory limit to 30 mg. per cent. In the Forney study, after drinking there was a very significant ($p<0.007$) impairment in the drinking group in the reverse gear event, the event in which there is the least habitual adaptation.

COMMERCIAL AVIATION PRACTICE

Probably no one would be in favor of allowing pilots of commercial airliners to have two beers before take-off. It may be presumed that there are not very many teetotaling commercial pilots and fewer teetotaling airline administrators, and yet most airlines have a common ironclad rule—"NO ALCOHOLIC DRINKS, NOT EVEN ONE BEER, WITHIN 24 HOURS OF FLIGHT TIMES." It may be guessed that this rule is shaded by some pilots occasionally, but this writer knows of one pilot who lost six months' pay for sliding over just a half hour. An airliner crash these days is an expensive affair.

Can we apply this same principle and practice in the motorcar field?

This writer is reliably informed by an American official residing in Sweden for nearly two years, and by four Swedish physicians whom he knows personally, that it is the duty of hostesses there to provide large quantities of orange juice for the drivers. It is expected that drivers will not drink alcohol at all on the afternoon and night that they are serving as drivers. Tomorrow they may be drinking, but today they are driving, and that is all that need be said. It is the accepted and expected thing. Deviant behavior is frowned upon.

Following the Stockholm meeting of the American College of Surgeons several years ago, several returning American surgeons wrote as did the following: "I noticed one very interesting thing at a major banquet given at the Golden Hall in Stockholm attended by 500 Scandinavian and American surgeons. Not a single one of the Scandinavians brought his own car since there were cocktails before dinner, and wine at the banquet. They all came by cab."

This is a realistic and practical social custom which we in the United States will do well to emulate. It is a cultural pattern that recognizes the facts of life (and death) on our highways.

THE CHRONIC ALCOHOLIC AS DRIVER

It must not be said that there is no drinking-driver problem in Sweden. The chronic alcoholic, comprised of three groups known as alcoholic addicts, alcoholic abusers, and excessive drinkers, constitutes 8.8 per cent of the adult male population of Sweden, and 13.7 per cent of the adult male population in Stockholm.[8] He accounts for over 30 per cent of the traffic accident victims. Among convicted drivers, 45 per cent belong to this group, against a figure, be it recalled of 8.8 per cent in the general adult male population.

As long ago as 1949, a Swedish Governmental Committee was appointed to study the problem of alcohol and motor vehicle traffic. We in the United States are just beginning to become aware of the role of the chronic alcoholic in our traffic picture.

This individual does not respond to safety campaigns, slogans, or even to lectures by judges or terms in jail. He is a compulsive drinker, and our traffic records, if we but knew it, are full of his repetitive acts until he finally kills himself, having killed one or more others before this sought-for event.[13]

In the definitive study by McCarroll and Haddon,[11] 46 per cent of the accident responsible drivers had blood alcohol concentrations in the very high 0.25 per cent range. This represents the alcohol in 10 drinks. In contrast, not a single one of the drivers in the 258-member control group, i.e., drivers interviewed later at the same hour of the same day of the week at the site of the fatal accidents, had a concentration in this range. These writers suggest the possibility that these persons were chronic alcoholics.

GRAND RAPIDS FINDINGS

In the monumental Grand Rapids study by Borkenstein and his co-workers, among 3305 accident-causing drivers, there were 18 with blood alcohol levels of 0.25 per cent or higher, and in the 7590 drivers in the control group, there was only one with this much alcohol in his blood.[3]

What is the solution of the drinking driver problem, which the world around is admitted to be the largest part of our traffic death and injury problem?

It is as difficult as to which comes first, the hen or the egg.

We need social maturity to get realistic legisla-

Doctor Campbell is Chairman, Automotive Safety Committee, Colorado Medical Society. Formerly: Member, Committee on Alcohol and Drugs, National Safety Council, Vice Chairman, Committee on Medical Aspects of Automobile Injuries and Deaths, American Medical Association.



tion, and we need realistic legislation to get social maturity.

Professor Goldberg submits that the present Scandinavian cultural patterns have developed under the impact of strict legislation actively enforced. Professor Vamosi[15] adds the really essential item: public education. He writes, "History has shown us that a long-lived success cannot be gained by measures of repression alone. A vigorous campaign of public education, and of drivers in particular, must be kept going constantly . . . It will be necessary to refer time and again to the problem from new points of view; this task must be performed by cinema-shows (the National Safety Council has yet to run a three-minute short, new each week, in every movie theatre in the land), lectures, billboards, television, and broadcasting. The fact that in the CSSR, hundreds of thousands of drivers have taken part in discussions concerning the new traffic regulations, proves that it is possible to produce a fudamental change in the views which are held by the general public concerning the drinking of alcohol.

"Finally, all the traffic police have been equipped with an apparatus for examining the content of alcohol in the breath. This enables the traffic police to assess on the spot whether or not the driver has taken alcohol. The knowledge of this fact has exercised a great influence upon all drivers. Every driver knows that a control block may be set up at any moment, and this possibility has a good educational effect".

As regards the detection and control of the chronic alcoholic driver, in this City one does not have far to look. The Psychopathic Clinic, under the direction of Mr. Alan Canty, attached to Detroit's Recorders Court, needs a counterpart in every American city, of even the smallest size. It is a happy coincidence that the city that produces the automobile has produced the first court to set up a special department to study the problem driver.

SUMMARY—CONCLUSIONS

1. At least 60 per cent of our fatal traffic crashes involve a drinking driver. (About the same proportion of fatally injured adult pedestrians have been drinking.)

2. Blood alcohol levels of 0.05 per cent (50 mg. per 100 ml. of blood) (currently legally permissible) produce impaired driving behavior in a substantial proportion of people.

3. If the object of legislation is to prevent motorcar crashes, then the statutory level should be at that level below which impairment does not occur, i.e., 40 mg. per 100 ml. of blood, or perhaps 30 mg.

4. The Scandinavian nations have developed a cultural pattern in which drinking driving is reduced in a realistic and practical manner.

5. Legislation of the implied consent type should be adopted by each and every State. It is needed for the prosecution of the individual case, and in order to collect realistic data as to the incidence of drinking-driving in each and every jurisdiction.

6. The chronic alcoholic or problem drinker plays a far larger role in our traffic death and injury problem than has been recognized in this country.

7. Special legislation providing medical or psychiatric treatment for the problem drinker is required. The old familiar round of license revocation and re-conviction does not meet this aspect of the problem effectively.

8. Most of all, we in the United States must meet the drinking-driver problem in a rational, nonsentimental, civilized manner.

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A project was undertaken to make bacteriologic diagnoses in cases of sore throat more appealing to the clinician. Both conventional culture technique and the new fluorescent antibody technique (FA) were used in the study. A total of 627 throat swabs were submitted to the Laboratory and evaluated. Results were reported to the submitting physician in from six to eighteen hours after submission. Both methods proved to be acceptable. The project did in fact stimulate interest in making etiologic diagnosis in cases of sore throat.

The Rapid Identification Of Group A Streptococci in Throat Swabs, A Comparative Study of Two Methods

By JOSEPH A. PRESTON, M.D.
Jackson

The cause and effect relationship of antecedant respiratory disease (ARD) caused by Group A beta-hemolytic streptococcus and subsequent acute rheumatic fever is a well established fact.[1,2] The desirability of identifying Group A beta-hemolytic strep as the etiologic agent in ARD is self evident. Stollerman[3] pointed out the futility of attempting a clinical diagnosis of streptococcal pharyngitis. Although students of rheumatic fever continually stress the need for making an etiologic diagnosis there is a lethargy on the part of the clinician to utilize throat culture in evaluation of streptococcal pharyngitis. Routine throat cultures are time consuming, and at times perhaps expensive. The practicing physician is reticent to wait 24 to 48 hours before treating acute respiratory disease particularly in children. The introduction of the identification of Group A beta-hemolytic streptococci by fluorescent antibody technique (FA)[4,5] offers a tool for both the rapid and precise identification of these organisms.

A study was undertaken at the Mercy Hospital Laboratory in the fall and winter of 1963-64 to evaluate the possible use of FA technique in identifying Group A "strep" in throat secretions. The objectives were: (1) to test the hypothesis that a rapid accurate diagnosis would stimulate greater interest in making etiologic diagnosis, (2) to test the feasibility of using FA as a method screening large numbers of throats on the community hospital level, (3) to compare FA technique with routine cultural technique in terms of facility and cost.

This study was supported by a grant-in-aid from the Michigan Heart Association.

MATERIALS AND METHODS

The FA identification of beta-hemolytic streptococci was offered to all physicians on the staff of the Mercy Hospital, Jackson, Michigan. The period covered by the study was from September 1, 1963, through February 29, 1964. The physicians participating in the study were provided with calcium alginate swabs and Stuart's Transport Media.* The throat swab was taken in the physician's office at time of initial examination. The swab is placed in Stuart's Transport Media and delivered to the Mercy Hospital Laboratory directly, usually by the parent or the patient. Both conventional culture technique and fluorescent antibody technique were used in identification of streptococci, usually simultaneously.

Conventional Culture Technique.—A modified Maxted[6] disc method was used. The swab was streaked on one half of a 5% sheep blood agar plate. A 0.02 unit bacitracin disc was applied to the heaviest portion of streaking. The plates were incubated under 10% CO_2 at 37°C, for from eighteen to twenty-four hours. The approximate number of typical beta-hemolytic colonies was recorded. Those

*Consolidated Laboratories, Chicago Heights, Illinois.

beta-hemolytic organisms inhibited by the bacitracin discs were cataloged as Lancefield Group A.

FA Technique.—The same swab used for conventional culture was innoculated into a screw cap vial containing 10 ml. of Todd-Hewitt Broth. The broth was incubated at 37°C for from two to four hours. After incubation the vial was centrifuged, the supernatant decanted, and the sediment washed once with 10 ml. of buffered saline (ph 7.2). The vial was re-centrifuged and the sediment was transferred to a glass microscope slide placing the sample in the center of an etched ring 1 cm. in diameter. The slides were dried for a few moments on a warm plate. They were stained for thirty minutes with a drop of fluorescent Group A streptococcal antiserum.† Next the slides were rinsed twice in buffered saline and blotted dry. Slides were mounted with glycerol and examined under the ultraviolet microscope. A monocular microscope equipped with a darkfield condenser was used. A Fluoralume Illuminator** was used as the U-V source. A Schott BG-12 exciter filter and a Schott GG-9 barrier filter were used. The smears were scanned under low power and examined definitively under high power. Characteristic yellow fluorescent chains of cocci were seen in positive preparations. Positive and negative controls were used throughout.

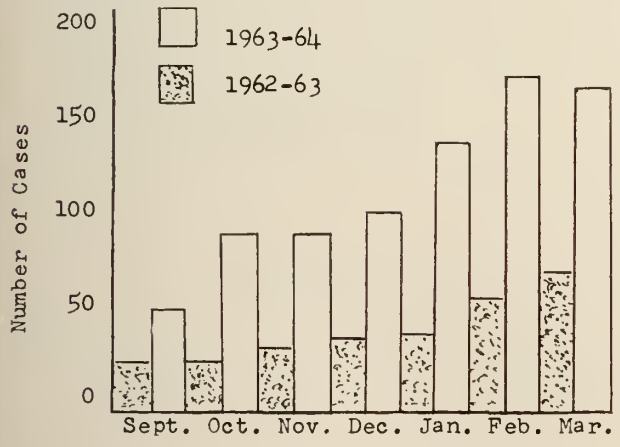


Fig. 1

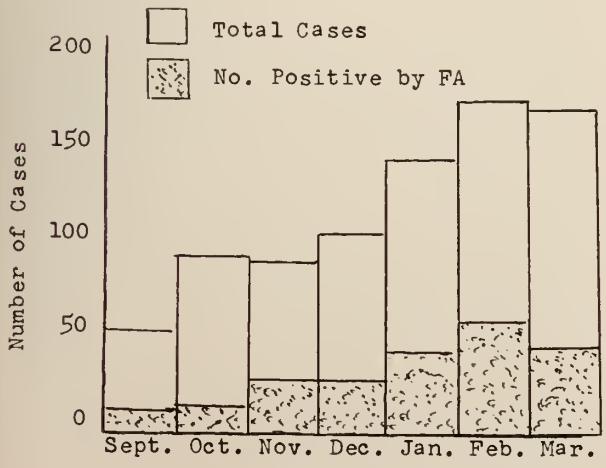


Fig. 2

RESULTS

A total of 627 throat swabs were submitted during the period of study. The material was submitted by some eighteen physicians. It is interesting to note however that eight physicians submitted 525 of the specimens. Approximately one half of the physicians seeing patients subject to acute respiratory disease participated in the program. There was equal interest on part of generalists and pediatricians. In addition to the 627 cases submitted during the study an additional 170 were submitted the first four weeks following the study. These are included for comparative purposes.

Figure 1 shows the cases submitted by the month through the course of the study, September 1963 through February of 1964. It also shows the number of cases submitted by the month during the same period of time one year prior to the study. In addition, it compares the cases submitted the first month immediately following the study (March).

Figure 2 shows the number of positive cases reported by the month through the period of study and includes the first month following study.

All 627 cases had simultaneous FA and culture done. In 300 of the cases, FA and culture with bacitracin discs were done. Tables I and II summarize these data:

TABLE I. COMPARISON OF FA WITH CULTURES ONLY
(627 cases)

FA + Culture —	FA — Culture +	Beta-Strep not Group A
17 (2.7%)	5 (0.8%)	5 (0.8%)

TABLE II. COMPARISON OF FA WITH CULTURES AND BACITRACIN DISC
(300 cases)

FA + Group A disc —	FA + Group A disc not readable	FA — Group A disc +
5 (1.7%)	14 (4.7%)	0 (0%)

DISCUSSION

This study stimulated, or at least reawakened, interest in making etiologic diagnosis in cases of acute respiratory disease. The number of cases studied during this project was three times the expected load. It is interesting to note that although the study ended in February, interest was continued through the following month in which 170 additional cases were submitted as compared to 66

†Difco Laboratories, Detroit, Michigan.
**American Optical Company, Buffalo, New York.

cases submitted in March the year before. It is expected that this interest will continue.

The use of fluorescent antibody technique did not inflict an undue burden on the bacteriology section of the Laboratory. Reports were available usually six hours after the sample was submitted to the Laboratory. Most of the time spent in fluorescent antibody technique is waiting time including: incubation, centrifugation and fluorescent staining. It took from two to three minutes per case for the actual microscopy. Samples which were submitted to the Laboratory before noon were reported by 5 p.m. the day of submission. Samples that were submitted in the afternoon were processed in the early evening and were ready for reading the same night. Reports were made via telephone to the physician's office at 8 a.m. the following morning.

This work confirmed the accuracy of FA compared to methods available in most bacteriology Laboratories. Estela[7] in a study of some 6500 throat swabs found 100 per cent agreement between precipitin grouping and FA. He found a 3 per cent false positive and a 7 per cent false negative rate in comparing precipitin with bacitracin disc grouping. These data would indicate that the FA technique for routine clinical use will provide a simple and accurate method of identification without using longer and more cumbersome cultural or precipitin techniques. Our data tends to confirm his observation in comparing bacitracin disc technique with FA technique. However, in this study the bacitracin disc was applied during initial culturing instead of applying it to pure subcultures. It will be noted from Table II, that we had a 1.7 per cent incidence of false negative by this method and no false positives. We did however have a 4.7 per cent incidence in which it was technically impossible to determine whether or not inhibition had occurred on the plate. This was usually due to a heavy overgrowth of normal flora admixed with a small number of beta-hemolytic colonies. Petran[8] in a study of 439 cultures found the same degree of correlation. It would appear therefore, that either method of identification of Group A beta-hemolytic strep is acceptable. The fluorescent antibody technique provides a somewhat more rapid and highly precise method which is readily adaptable to any Laboratory doing routine throat cultures. However, identification of Group A streptococci by the use of the bacitracin disc on primary isolates provides an excellent secondary method. Whether a six-hour report is any more valuable than a twenty-four hour report is a moot point. Certainly the six-hour report has a little more psychological appeal, both to physician and parent. In either event the 24-hour delay in proper treatment of streptococcal pharyngitis is not detrimental in rheumatic fever prophylaxis as long as the concept of adequate antibiotic blood level for a minimum of ten days is rigidly adhered to.[9]



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SUMMARY

During the fall and winter of 1963-64, some 627 throat swabs were submitted to the Laboratory for identification of Group A beta-hemolytic strep. Both fluorescent antibody technique and culture technique including bacitracin disc identification were used and compared. There was a good degree of correlation; either method appeared acceptable. The fluorescent antibody technique was a bit more rapid. However, identification of beta-streptococci with bacitracin disc on primary isolates was found to be acceptable. The study stimulated an interest in throat culture in the medical community.

ACKNOWLEDGMENT

I should like to acknowledge the technical assistance provided by Mrs. Betty J. Rice and Mr. Robert Watson.

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Fig. 1. (A) Postoperative appearance of right shoulder with loss of normal fullness resulting from absence of deltoid.

(B) Abduction in neutral rotation accomplished without scapular shrugging.

(C) Abduction in external rotation especially effective because of help of shoulder flexors.

(D) Full overhead abduction.

(E) Extension or backward elevation limited to about 50 per cent of normal. (Note patient is using her thumb to "climb" to greater degree of extension.)

Complete Deltoidectomy For Malignant Tumor

BY SIDNEY C. WALKER, M.D., PORT HURON

The orthopedic surgeon is frequently confronted with the serious problem of deciding how radical he must be in treating malignancy of the soft somatic tissue. All too frequently the patient subjected to mutilating ablative surgery succumbs a short time later to distant metastases. In such a case a local excision would have been just as helpful and the patient would have had a more normal terminal period. On the other hand, when metastases have not yet begun, a wide local excision may effect a cure as long as the total lesion is removed.

It is hoped that the case to be discussed is one in point in favor of this latter approach.

Our purpose here, however, is twofold. In addition to showing the efficacy of wide local excision in soft tissue sarcoma, this particular case is of interest because it has enabled the author to evaluate shoulder function following complete removal of the deltoid muscle.

CASE REPORT

A seventeen-month-old female infant was first seen December 9, 1960, presenting a soft tissue mass in the right lateral upper arm. The lesion measured 2.5 inches by 1.5 inches, was smooth in contour, non-tender and was felt to be a solid tumor. It was quite well delineated, moved rather freely and was definitely not associated with osseous structures but seemed to arise from within the deltoid muscle mass. The parents had first noticed the lump about one and one-half months prior.

X-rays revealed definite evidence of a soft tissue mass overlying the proximal third of the right humerus without evidence of bone involvement. The initial clinical

impression brought the following three diagnoses to mind: benign fibroma, hemangioma and fibrosarcoma.

Excision biopsy was carried out and a spindle shaped solid tumor was removed from within the deltoid fibers. The mass was overlying the proximal humeral shaft and was deep within the deltoid fibers but was not attached to periosteum or bone and could be shelled out largely by blunt dissection. The superior pole, however, had to be excised with the dissection knife at a point where it appeared to arise from intermuscular septal connective tissue. Gross appearance of the lesion led the pathologist to believe that the tissue was benign, but subsequent microscopic diagnosis was spindle cell sarcoma, grade two, with invasion of adjacent skeletal muscle. The most logical course of action seemed to be a secondary wide local muscle excision and hence a complete deltoidectomy was performed without reinvading the biopsy area. Final microscopic scrutiny revealed no evidence of residual sarcoma in the muscle mass removed.

It has now been over three years since operation and there is as yet no evidence of recurrence of the tumor or of distant metastasis.

Postoperative clinical evaluation of the shoulder girdle (Fig. 1, A-E) reveals active motor function in all directions through a full range of motion with only a slight decrease in strength, with one exception. Extension (or backward elevation) can be accomplished to only about 30 degrees instead of to a normal 60 degrees or more and then not without slight scapular shrugging. All other motions, however, including abduction in neutral rotation, forward flexion and internal and external rotation can be carried out normally with satisfactory strength. Abduction in neutral rotation is somewhat weaker than in external rotation because in the former case the arm does not have the assistance of the pectoralis major, biceps, and coraco-branchialis and can muster only the supraspinatus and to a lesser extent the infraspinatus.

No evidence of sensory loss in the upper lateral aspect of the arm can be found, but this evaluation is somewhat unreliable because of the patient's young age.

WIDE LOCAL EXCISION

All factors available must, of course, be taken into consideration in making the decision of amputation vs. wide local excision. These factors include location of the tumor, size of the tumor, probable duration of existence of the tumor, clinical gross appearance of the tumor, and certainly most important, the microscopic grade of malignancy and the advice of the pathologist.

In this particular case, the location of the lesion high in the upper arm made shoulder disarticulation or fore-quarter amputation mandatory if a more radical approach was to be pursued. The lesion was small and so well delineated that a diagnosis of benign growth was entertained pre-operatively. Alert, intelligent parents had gotten the patient to the physician within two months following their first observation of the tumor. Grossly, the pathologist and the surgeon both felt that the lesion was likely benign. The greatest deterrent to less radical treatment was the microscopic picture of sarcoma, grade two, with invasion of adjacent muscle. Full consideration of all factors, however, favored wide local excision. The wisdom of this decision, of course, was further borne out by the second microscopic report which showed no evidence of malignant tissue in the deltoid mass. This less radical approach was followed, however, with full cognizance of facts well expressed by the following quote from Ariel and Pack.[3] "The high recurrence rate emphasizes the futility of attempting excision except under most favorable hospital conditions with a competent pathologist in consultation and with the surgeon prepared to perform the most radical surgery when indicated. Inadequate excision traumatizes the tumor, always results in recurrence, and possibly enhances the occurrence of metastases."

It is well realized that in this short period of three years the entire story may not have been told and a recurrence is still possible. The picture thus far, nevertheless, is quite encouraging since a primary recurrence usually occurs much sooner than three years and a metastasis is now somewhat unlikely.

COMPLETE DELTOIDECTOMY

Hollinshead[2] states that usually, with paralysis of the deltoid, abduction is limited to about 45 degrees. Callander[1] writes that the first 15 degrees of abduction is effected by the supraspinatus, the next 75 by the deltoid. These authors are essentially in agreement in that they relegate the initiation of abduction to the supraspinatus and its completion to the deltoid. Staples and Watkins,[4] however, in an excellent paper on evaluation of shoulder function after traumatic paralysis of the deltoid, have previously described the resultant near normal action exactly as the present author has found it. The clinical picture following deltoidectomy, as described in the above case report, reiterates almost identically the findings of these authors after specific paralysis of the deltoid from trauma to the axillary nerve. It now seems certain that in the absence of the deltoid only, remaining shoulder muscles function with adequate strength and carry the arm through a normal range of motion in a smooth, coordinated fashion with the exception of extension which is limited to about 50 per cent of its normal range.

SUMMARY

A case report has been presented in which a seventeen-month-old child has been treated for a fibrosarcoma of the soft somatic tissue of the upper arm. Wide local excision by means of complete deltoidectomy was the treatment rendered. Although only three years have elapsed, there is as yet no evidence of recurrence or

metastasis. With regard to the absence of the deltoid muscle, the author's findings are very similar to those of Staples and Watkins in noting the resulting near normal function of the shoulder joint. This additional example of shoulder function when there is selective absence of the deltoid would seem to substantiate the fact that, with the exception of shoulder extension, the deltoid is in most cases a purely assistive muscle with little specific action of its own, and that it can be sacrificed without significantly altering shoulder function.

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We Are Not Sufficient Unto Ourselves

By Bernard Luck, D.D.S., Chairman,
Michigan Cancer Coordinating Committee

"People's lives are not saved in the laboratory. Lives are saved where people are."

This was said by George Papanicolaou, MD, in urging the public and the medical profession to make full use of the tools that have been created for the control of cancer.

To promote the greater use of these tools in Michigan, the groups in this state most concerned with cancer have joined together to form the Michigan Cancer Coordinating Committee. Created in 1953 as the result of the foresight and urging of Wm. Hyland, MD, the Michigan Cancer Coordinating Committee helps these organizations, each with unique resources, to win gains over cancer that would be beyond their individual reach.

The statistics and nature of cancer are such that a unified attack on this disease is of major importance. This Committee reflects the spirit that is unifying the will and the resources of all mankind into a knockout blow against cancer.

The physician and the dentist joining hands with the researcher, the American Cancer Society and all of its units, the Michigan Cancer Foundation, the State Health Department and Health Officers Association and all the interested public who do so much, has created a team exemplifying a unity of purpose. Success will follow if we maintain cooperation, with no division of interest.

This togetherness, reaching to the grassroots of human nature, will result in a much earlier dissolution of the Cancer curse. Division and overlapping of effort, loss of personal contact and effort, all tend to make the fight a more expensive one, not only from the monetary standpoint, but in human life.

The fight against Cancer in Michigan is in good hands. We are organized to take a realistic view of the problems involved in public and professional education; we are working toward improvement in early diagnosis and treatment, compiling statistics, furthering research, and raising funds to make all of these objectives possible.

Working with people, reaching them in their homes, encouraging them to be members of our team, giving them the privilege of supporting this fight physically and financially, cannot help but hasten the ultimate—Victory over Cancer.

Let us stay united and live.

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Fig. 1. Large surgical amphitheatre, Charles University Medical School, Prague.

Brief Medical Tour In Russia

By HAROLD A. FURLONG, M.D., F.A.C.S.
PONTIAC

The announcement by the World Medical Association of a medical study tour of Russia was an irresistible opportunity for a look behind the Iron Curtain. Although we recognized that there would be travel inconveniences (which later materialized), some inquiries convinced us that the visit would be safe, reasonably comfortable and vastly interesting.

Prague

We landed in Prague October 12, tired after twenty-four hours of travel.

Our first breakfast was a surprise as we were not accustomed to caviar, dill pickles and beer at that time of day. The rest of the day was a delightful experience in visiting the many cultural points of interest.

The second day, our party of doctors went to the various clinics of ancient Charles University Medical School. Professor Krause, the Chief of Gynecology, was most hospitable. His senior instructor spoke quite good English, and seemed pleased to have a chance to use his knowledge. The Gynecology Department occupied a large three-story building which impressed me as being somewhat drab. The patient beds were low cots, linen was unstarched, and there were very few visible comforts for the patients. Nursing, custodial and maintenance help appeared to be plentiful and the housekeeping was good.

In the operating suite, there was a commodious supply room that opened into the large surgical amphitheatre (Fig. 1). Most of the light came from the large windows along the outside of the room. Above each operating table, of which there were three in the room, were some rather antiquated overhead lights. We found that two or three operating tables in one large surgical room was the usual practice in Russia also. A radical vulvectomy for recurrent carcinoma was in progress. The surgeons seemed quite skillful. The instruments were certainly adequate if not new. Intratracheal anesthesia was being used and blood and intravenous fluids were in use or available. Cotton sutures were used entirely.

The next day, a hysterectomy was observed. My sympathy was real for the gynecologists who were obviously handicapped by the obesity of the patient, a situation not uncommon in our own country. When we were leaving the clinic the opportunity seemed propitious to ask some questions. The medical staff is all too well aware of the watchful eyes of the Communist officials. The income of the doctors is very low. The head of the department receives about three thousand dollars a year. Senior assistants receive less and for the years spent in medical studies, including specialization, the rewards are meager. My guide had a wife and two children, and living is not cheap behind the Red borders. Medicine is completely socialized.

Prague is an ancient smoke-grimed city, rich in history and culture. The streets have no traffic problem as automobiles are relatively scarce, and for the most part they are official cars. Streetcars and buses are numerous and crowded. The people



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do not look at all undernourished. Clothing is better than in Russia itself. The stores in the center of the city are abundantly stocked, at least with food, clothing, appliances and confections. How readily the people can afford to purchase them is a question, because purchasing power is low and everything by our standards is expensive. Recalling that Czechoslovakia was a flourishing democracy before it was overrun by the Germans and did not became a vassal of Russia until the defeat of Hitler, it was our feeling that Czechoslovakia was not so completely communized as Russia.

It is important for all of us to have as much information about Russia from as many different observers as possible.

Each one, whether banker, lawyer, industrialist, politician or physician, sees something different. A physician's view is presented.

Moscow

After weeks of anticipation our arrival in Moscow proved disappointing. It was almost midnight. Hot soup had been prepared for us in a spacious airport dining room. That was welcome. Meals aboard Russian planes are pretty grim. A broad new super-highway leads to the city, but all was dark and cold. The apartment buildings were dark and the street lighting reminded one of the war-time partial black-outs. We were unable to make advance hotel reservations so we were forced to go wherever Intourist took us. This may be due to an actual shortage of hotel rooms and an effort to use all available facilities to the best advantage.

The Research Institute of Obstetrics and Gynecology was the first medical institution visited. (Fig. 2.) It is located in a very large building that could easily pass for a government office building. Under the direction of the Ministry of Health, U.S.S.R., the institution is devoted to research and postgraduate training in obstetrics and gynecology, according to a prearranged seven-year plan. In the obstetrics department, there are 145 beds, 45 of which are for pregnancies with pathology. The obstetrical beds, including labor, delivery and postpartum areas, are divided into two separate units. All the patients are delivered and cared for in one unit for one week. The unit is then closed and cleaned and the other unit comes into use. This is probably an effort to control possible infections.



Fig. 2. Research Institute of Obstetrics and Gynecology, Russia.

The gynecology areas also have 145 beds for surgical cases, endocrinology and for child gynecology —15 beds. There are the usual ancillary services for biochemistry, physiology, pathology, etc. It is a very complete central teaching center, supplemented by four clinical branches elsewhere in the city with 600 beds in maternity homes. There are district welfare centers throughout the city from which patients are channeled to the maternity homes or the Institute.

Great attention is paid to psycho-prophylactic preparation for childbirth. The Institute is the stimulus for the lectures and demonstrations in the maternity homes and welfare centers as a part of prenatal care. The classes for expectant mothers are carefully planned and conducted.

Even in the Institute, photographs, posters and propaganda were in great evidence. Some patients who are judged to be emotionally unprepared for labor and delivery receive extra attention. To test their readiness, each patient is placed in a darkened sound-proof room, and connected by several leads to a polygraph located outside. The reactions of the patient to the cacophony of sounds and lights are recorded on the polygraph. This particular practice seems to be a corollary of the conditioned-reflexes theory of Pavlov fame which have great significance in Russian medicine.

Labor rooms have as many as twelve beds. One patient we were told was ready for delivery. The silence was profound. We questioned the use of sedation in labor but received no satisfactory answer and concluded it was not intensively used. Cesareans are performed in a separate surgical suite. Midwives conduct all normal labors. Postpartum patients remain ten days in the hospital. Early ambulation is not practiced. No regional anesthesia is used. Fathers are not allowed in the postpartum rooms, which means they do not see spouse or child for ten days. Most doctors are women. One male doctor was seen who was performing tubal insufflations. There are two or more operating tables in each surgical room, as we found in Prague. The



Fig. 3. Ultrasonic sound apparatus, used in study of pelvic tumors.

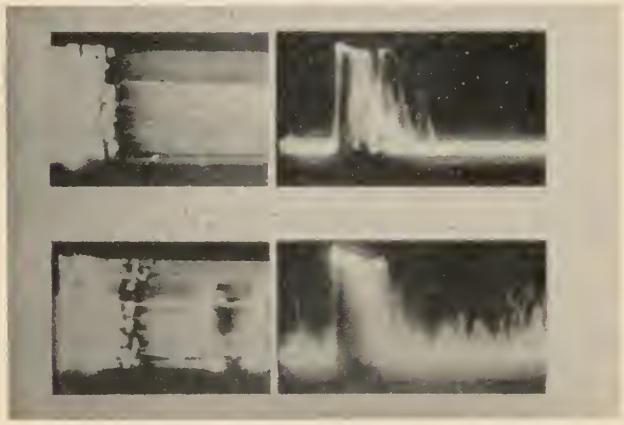


Fig. 4. The use of this machine in tumors of the genitalia. The top picture: Echogram of the uterine myoma (only the anterior wall of the tumor is shown). The bottom picture: Echogram of the biloeular ovarian cyst.

operators wear their street clothes under their sterile gowns.

One of the research projects in gynecology was the use of an ultrasonic sound apparatus, called UZD-4, in the study of pelvic tumors. The large cabinet (Fig. 3) projects on a screen the sound waves producing what the investigators call an echogram. In a solid tumor the sound waves are reflected from the anterior wall of the myoma, whereas in a bilocular ovarian cyst the sound waves pass through the fluid and reveal anterior and posterior walls (Fig. 4). Over one hundred patients had been studied with the machine and were to be used in a scientific paper for later presentation in London. The practicality of this device was not apparent to us.

Other procedures in common usage in this country were in vogue in Russia, namely, pneumo-peritoneum, endoscopy and laparoscopy. In women under 35, when it is necessary to remove the uterus for early carcinoma, a nutritive pedicle is left on at least one ovary, and that gland is then transplanted superiorly near the kidney. Later, when radiological treatment is given, the function of the ovary is preserved by proper shielding. Much more could be written of this excellent institution with its very extensive library filled with the medical journals and books of the entire world.

Of considerable scientific interest was the permanent Industrial and Agricultural Exhibition on a fifty-acre tract on the edge of Moscow. The latest developments in electric power production, agriculture, heavy industry, medical science, health, education, sanitation, petroleum and chemicals were extensively displayed and very attractively arranged. One building was largely occupied with the models of the latest Russian space projects from Sputnik to the most recent satellites. Audiovisual demonstrations were in operation and attracted crowds of interested people.

One entire building was devoted to medical science. Newly developed instruments and apparatus such as diagnostic cystoscopes, endoscopes and the usual surgical armamentarium were shown. We were attracted to the stapling gun they have developed. This instrument uses tantalum U-shaped staples mechanically to suture any hollow organ like the intestine or hilus of the lung (Fig. 5). This would be especially useful in doing a lobectomy. The largest gun will insert a row of staples up to 60 mm. Many of the devices displayed were developed by the Scientific Research Institute for Experimental Surgical Apparatus and Instruments. This body, composed of engineers, physicians and scientists of several disciplines, is under the direction of the Ministry of Health, U.S.S.R. The large staff designs and improves scientific apparatus, which we found were sale for abroad. Catalogues in English, French and Russian were distributed to visitors.



Fig. 5

Leningrad

The days spent in Leningrad were especially enjoyable. The city is not quite so feverish as Moscow appeared to be, and reflects more of the pre-revolutionary Russia in its numerous historical and cultural buildings. Our group spent the morning under the guidance of Professor Shustin at the main center of the Pavlov Institute, which has four branches elsewhere in the city, each concerned with some different phases of study pertaining to dis-

eases of the nervous system. We had witnessed the practical use of the theory of conditioned reflexes in the Research Institute of Obstetrics and Gynecology in Moscow. It is not possible in this article to describe the work of this Institute as we heard it related. Research is directed to the study of the physiology of the highest nerve centers, such as sight, and the localization of various trophic areas of the lobes. After lobectomy, performed by surgery or electrically, the loss of functions such as salivation, coordination, spasticity and genital reflexes are investigated. It appeared that the Institute was endeavoring to expand the frontiers of knowledge of nervous diseases beyond the work of Pavlov at the time of his death.

Visiting a marriage palace may not be of medical importance but it was of considerable sociological and human interest value. After the revolution in Russia a marriage was a very perfunctory affair. The populace found this very unsatisfactory and probably under pressure the regime was forced to upgrade matrimonial arrangements for the people. As we well know, marriage in Russia had always been quite a festive occasion. Marriage palaces were established in some of the confiscated residences of the old nobility. This gave much more significance to marriage ceremonies for even in Russia the family is important to the state. We were fortunate in being witnesses of the nuptials of a comely young lady and an equally attractive young man (Fig. 6). After a visit to a state farm, which in itself was an adventure, we left Leningrad for the south of Russia.

Odessa

Our hopes of a warmer climate disappeared in thin air as we arrived in Odessa on the shores of the Black Sea. There was no heat in the hotel and we were most uncomfortable. Odessa is the location of the famous Filatov Institute for Research and Treatment of Ophthalmological Diseases. It is quite a large hospital, and more cheerful than others we had seen. We were guided by the woman director who spoke excellent English and who was most pleasant and eager to show us around. Patients are channeled here from all over Russia for treatment of eye diseases. Filatov had carried on extensive research and experimentation in corneal transplants and keratoplasty. Since his death in 1956, his work has been actively continued. Cadaver corneas are used, being sent from various cities in Russia for the corneal bank. Traumatic conjunctivitis, especially from lime burns, is very common among the patients.



Fig. 6. Wedding in marriage palace.

Filatov became interested in his later years in the therapeutic use of tissue transplants. He believed as a result of his experiences with corneal transplants that tissues of animals and plants acquire curative properties when isolated under adverse conditions.[2] He felt that biochemical changes resulted in the production of substances he called "biogenic stimulators" which, when introduced into a sick organism, stimulate vital reactions and promote recovery. He implanted animal and plant tissues, injected them subcutaneously, and later prepared aqueous extracts for use. He considered his work in the therapeutic use of tissue cultures to be his greatest achievement. After his death in 1956, his experiments were continued. Results have been claimed in many diseases, from parenchymous keratitis, atrophy of the optic nerve, bronchial asthma, leishmaniasis and a long list of other conditions. The members of the visiting party were not impressed by the claims for tissue therapy; in fact we began to raise our eyebrows and became very skeptical.

On returning home a search in current literature was made. While Filatov is mentioned in two articles it is my impression that therapy of tissue culture has not been as sympathetically received in American medicine as it has been noted in European and Russian practice.[1] Whenever a therapeutic measure is claimed to have such brilliant results in such a diversity of diseases, doubts arise.

Yalta

We were glad to leave the chilly hotel of Odessa and looked forward to Yalta, expecting warmer weather and we were not disappointed. Medically Yalta is not important but has great historic appeal as the location of the famous conference between Stalin, Churchill and Roosevelt during the Second World War. Yalta now is a rest area with many sanitariums located in the homes of czarist nobles. The climate is mild, the summer being especially pleasant. The famous Russian novelist and dramatist, Chekov, made his home there for several years and the residence is maintained as a museum for the literati. Incidentally, Chekov was a doctor of

medicine who spent many years in a remote Siberian village working among the poor. He contracted tuberculosis there and eventually succumbed to that disease.

Socchi

Socchi on the east coast of the Black Sea was a delightfully warm and pleasant place to visit. The hotel was the best we had encountered. The flowers were profuse, palm trees were everywhere, and yet in the distance we could see the snow-capped Caucasian Mountains. Our medical attention was aroused by the elaborate sanitariums, of which there are fifty. The area is noted for the mineral waters present and the prevalent odor is quite apparent. The Matsesta Clinic is the center to which patients are sent from the surrounding rest homes and sanitariums for hydrotherapy. Appointments are made, the patients come in buses for their treatments. About 30 buses were parked in the area while we were there. Citizens are sent from their homes for a month, at no cost to them. Each carries a little notebook like a passport in which his treatments are recorded. Rheumatism, arthritis, hypertension, cardiac disease and upper respiratory diseases are given hydrotherapy supplemented by batteries of electronic gadgets.

Tashkent

In the southeast part of Russia, near the Afghanistan border, is the Republic of Uzbek, of which the capital is Tashkent. The Tashkent State Medical Institute is a postgraduate training center for most of the republic. A very great effort is being made to provide adequate medical personnel for an area which in the past apparently has been very inadequately provided with health and medical facilities. About 4000 students are in training. General medicine, sanitation, pediatrics and stomatology are taught in the postgraduate school. By attending evening class, students may complete their work in three years, and obtain their degree, and then spend a year in the daytime clinics and be prepared for general practice. After completing the studies at the Institute, students are sent into the country, wherever needed. At the end of two years they may return for special examinations at region hospitals. They are thus certified for certain operations. After a year of advanced training in the Institute, they may specialize for three years. About 12,000 doctors have been trained in specialties, and 10,000 assistant doctors, half of whom are natives, have studied here. Midwives are trained in special secondary schools in each region. Maternities are established in each area as well as special hospitals, and air assistance is available. Students receive a scholarship of 35 rubles a month (about $31.50 in U. S. currency) and some help is expected from the families. Meals are from 1 to 2 rubles daily (90 cents to $1.80).

The Tashkent Maternity Home has 475 beds, and is the largest district hospital in the Uzbek Republic, with 225 delivery beds, 150 gynecology beds, 45 postpartum beds for complications and 80 beds for abortions. The abortion beds intrigued us. Abortions are legal and about 6000 are performed each year in this hospital. A special room containing three tables is set aside for abortions. Most are done under three months, and we were interested in the suction curette used. This is attached to an aspirating pump such as is commonly used in our hospitals. When one considers that 8000 babies are born in the hospital each year, the figure of 6000 abortions is appalling. We were told there were 36,000 women in the district surrounding the hospital, of which 15,600 are able to conceive. That would mean that about every second woman has an abortion. Contraceptives are sold in the maternal welfare centers. Each year, 124 cesarean sections are performed, and the figure given for maternal mortality was 0.5 per cent with infant mortality at 0.9 per cent. This seems exceedingly low for that area. We were informed that only 32 babies in Tashkent were born at home in 1960.

The Tashkent area is the great cotton producing center of Russia. The manufacture of machinery devoted to the production and processing of cotton is the leading industry. The cotton mill employs about 17,000 people. A polyclinic of 400 beds with 188 doctors and 435 midwives staffs the institution which takes care of the workers and their families. Everything from board to medication is free. Workers receive 60 per cent of their salary when ill, and 90 per cent for employees with seniority. A woman has 56 days leave before and after delivery with full salary paid. In case of complications or many children her leave may be extended to 75 days. Ten kindergartens and nine government nurseries take care of the younger children. Children are immunized at age five or six months for smallpox and diphtheria; polio injections of Sabin serum are given annually. Tuberculosis is prevalent in the area and preventive injections are given. Children receive oral medication for dysentery prevention after three years, while adults receive annual inoculations for typhoid, dysentery and typhus. Death benefits of 60 per cent of salary are given the family, and if children survive the pension is paid to the age of 18 years.

Samarkand

Samarkand is an ancient city of 200,000 people. Alexander the Great invaded the area in the fourth

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century B.C. The Chinese mentioned it in their writings in the fifth century A.D. In 1220, Genghis Khan and his Mongol hordes devastated the area. In 1335, Tamerlane made it the capital of his empire from Persia to India. The ruins of the capital are the great attraction of the city.

In 1924, the Institute of Parasitology was founded, largely to combat malaria which was the scourge of the region. Thanks to the use of DDT and Atabrine and improved sanitation, malaria is no longer a major problem. Now the Institute is majoring in the control of other parasites such as ascaris lumbricoides. Pigs, cattle and goats are very numerous, and sewage disposal is minimal. Leishmaniasis, kalaazar and elephantiasis remain to be eradicated. Russia is attempting to open to agriculture large areas of virgin land. These lands are infested with a squirrel-like animal called a suslik. The fleas they carry infect humans and the animals are being killed as rapidly as possible. As pure water is available, filariasis is decreasing in incidence. People infected with filariasis are not allowed to bathe in the public pools, and basins known to be infested are filled in with earth.

Bovine tuberculosis is extremely prevalent in the Uzbek Republic, and a 500-bed hospital for the treatment of bone tuberculosis is located in Samarkand. Of these beds, 250 are for children, and in one room we saw about 75 children under school age suffering from tuberculosis of the spine. They were lying in their half-body casts in their cribs, seemingly uncomplaining as they were very quiet, and well attended by flies. We were informed that children are sent here from nearby republics or satellite nations for treatment in the specialized hospital.

Russia

Russia is definitely not a place to travel if one is expecting to find standards of accommodations found in American or European hotels. The food is palatable but very ordinary. The Russians are hospitable and friendly to the Americans, wanting to know more about the United States. We were surprised by the number of people who spoke English, which is a secondary language in their schools. In the fields of education and health, the Russians have made great progress since the Revolution 45 years ago. The literacy rate is steadily increasing; in fact, a virtual explosion is taking place. Almost as fruitful as the encouragement given to education is the stimulus given to public health, particularly in medical education and disease prevention. In czarist days, these were sadly neglected. Whatever else we may read or think about Russia, it has vast potentialities in world affairs.

Russia is a populous country of unbelievably rich resources that is rapidly emerging from centuries of industrial, educational and social repression into what may be a modern industrial colossus in a very few years. When that time comes, unless Communism gradually undergoes a metamorphosis into a more moderate regime, the threat to the peace of the world will remain.

References

1. Rogers, Blair O.: Transplant Bull., 4(1):47, 1957.
2. Filatov, V.: My Path in Science. Moscow: Foreign Languages Publishing House, 1957.

Smoking-Health Materials Distributed to Teachers

A comprehensive program to help teach children about the health hazards in cigarette smoking will be distributed to educators throughout the state this fall. The program was offered on a pilot project basis in some 100 schools during the spring. Various State organizations and agencies are cooperating in the educational effort.

Henry J. VandenBerg, Jr., M.D., chairman of the MSMS cancer control committee, functioned in a key role during the initial phases of the program's formulation.

The MSMS House of Delegates urged this type of educational programming at its 1963 session, and the AMA House of Delegates called for informational efforts at its recent 1964 session.

* * *

Article Reprinted in South

Lifelines, the publication of the South Carolina Alcoholic Rehabilitation Program, has reprinted the JMSMS article (October 1963) by Richard C. Bates, M.D., Lansing, about "Clues to the Diagnosis of Alcoholism." Doctor Bates is chairman of the MSMS Committee on Alcoholism and Drug Addiction.

Journal Articles Abstracted

Abstracts of two recent MSMS Journal articles appear in the current issue of "LAB-QUICK," newsletter published by the Ames Company. The two scientific articles were by Robert A. Green, M.D., Ann Arbor, and associates, entitled "Unclassified Mycobacteria: Laboratory Experience," and by Albert DeGroat, M.D., Detroit, and associate, entitled, "Observations on Fluorescent Staining for the Detection of Acid-Fast Organisms in Sputa and in Tissues."

America's Number One Epidemic

A peculiarly American disease, so statistics tell us, is our national and apparently insatiable desire to destroy ourselves in automobile accidents.

As crash deaths and injuries mount, the obvious solution to this mania for self destruction lies in two areas—the driver of the automobile and the machine itself.

Imperative Education

Numerous programs, on national and local levels, are aimed continually at driver education—"Slow down and live" or "The life you save may be your own." It is obvious that driver training and education are imperatives, but as in any attempt to modify human attitudes, the program is slow. Automobile accident fatalities continue to rise in spite of official and voluntary efforts to turn the tide. We can only speculate at how high the statistics would soar if there were no driver education programs or accident prevention safety campaigns to hold deaths in check.

The other basic approach—concurrent with attempts to solve the human problem—is to the great big shiny machine the peculiarly motivated American uses to hurl himself down highways and byways.

The Measures

What can be done to the automobile itself to make it optimally safe? What can be done through research and manufacturing skill to protect the driver perhaps against himself, while others are working on his aptitudes and attitudes?

Four Michigan groups, in cooperation with Cornell Aeronautical Laboratory of Cornell University, are working on the answers to these questions. The Michigan State Medical Society, the Michigan State Police, the Michigan Hospital Association, and the Michigan Department of Health are the participating agencies. George H. Agate, M.D., Director, Division of Epidemiology, Michigan Department of Health, is serving as medical coordinator of the project.

Two previous two-year Automotive Crash Injury Research (ACIR) studies in Michigan ended on August 15, 1959, and April 1, 1962. During these initial studies a concerted effort was made by the cooperating agencies to report on all rural injury-producing accidents involving passenger cars in selected sampling areas of Michigan. With the approval of Michigan agencies an additional four-year study was begun November 1, 1963, during which only those injury-producing accidents in selected areas that involve passenger cars of the last four-year models are to be studied. As in the first studies, the limited study is to be conducted in the eight police districts for a six-month period as indicated in the accompanying list.

These are Michigan Police district area headquarters and serve as field coordination points for the eight field studies; only specified accidents investigated by the Michigan State Police are within the scope of the study.

The ACIR project in Michigan, to determine how automotive design can contribute to passenger safety, will succeed or fail based on reports supplied by Michigan physicians and State Troopers.

Period	*Date*	*District*
1	11/1/63— 4/30/64	#1
2	5/1/64—10/31/64	#7
3	11/1/64— 4/30/65	#4
4	5/1/65—10/31/65	#5
5	11/1/65— 4/30/66	#2
6	5/1/66—10/31/66	#8
7	11/1/66— 4/30/67	#6
8	5/1/67—10/31/67	#3

In Detail

The information from the Michigan State Police covers in detail the conditions surrounding the accident itself: road design, type of road, surface conditions, number of vehicles involved, estimated speeds, details of external damage to the involved vehicles, objects struck by occupants. Additional information is supplied by State Troopers on interior damage to the automobile, and photographs, when needed, will supplement the written report.

Step two in the chain of field research is the completion of the ACIR medical report form by the physician attending the accident victim. The form, which takes less than five minutes to complete, is given by the investigating trooper to the attending doctor or to the emergency room supervisor of the hospital to which the accident victim is removed. A separate medical report is submitted for each injured person; stamped self-addressed envelopes are supplied to physicians and hospitals to simplify submission of reports.

Coordination of reports from troopers and physicians is done in Lansing by the Michigan Department of Health. The package of field data is transmitted to Cornell Aeronautical Laboratory of Cornell University for intensive study. The physicians' reports are considered privileged medical information.

Will Not Disappear

Information from previous ACIR studies did not disappear into a statistical lost forest. Many life-saving features on the automobiles of 1964 came from these and similar studies. Strengthened door locks, recessed steering wheel posts, padded dash boards and sun visors, and, of course, safety belts are life-saving devices that might not be on our new cars without field research.

The need is obvious; the goal important and dramatic. For these reasons, the Michigan State Medical Society commends and supports the Automotive Crash Injury Research program.

MSMS Centennial Series: 1945, 1946

Michigan Foundation for Medical and Health Education Launched

— 1945 —

Before we tell the story of the work of the Society for 1945, I would like to say something about "Andy" Brunk, as we called him. I could easily use this page just to enumerate the work that this "Stalwart of Medicine" did for our Society and for the advancement of help to the sick.

I shall have to restrain myself and give the reader just a few of his contributions. He was very active in the Wayne County Medical Society and the Michigan State Medical Society, being President of each organization. He was a Founder and Former President of the Michigan Health Council. He was a well-known surgeon and owned the Marlin Place Hospital. Doctor Brunk died at the age of 67 on February 3, 1952. The title "Medical Statesman" could be rightly given him.

* * *

DURING 1945, BLUE SHIELD served 700,000 people. Approximately 200,000 persons received surgical services for which almost $8,500,000 was paid. MMS also repaid MSMS its original contribution of $17,544.

An amendment to the Michigan Constitution was proposed which would have controlled and dictated the future career of medicine. If voted in, it would have destroyed the private practice of medicine in this State.

A director of health insurance would have been authorized to make arrangements with duly licensed practitioners, specialists, consultants and clinics for services and supplies.

* * *

THE 1945 HOUSE of Delegates took the following actions:

1. A new statement was made to the effect that wards of the government were not indigent and that physicians should be paid for services to them.
2. The work of the Drafting Committee was approved to set up a group of principles that the profession would support when made the basis of national legislation amending the Social Security Act.
3. A special assessment of $25 was voted for various purposes, including a public relations and a public information program.

The outstanding activity of the new Michigan Health Council was the "Michigan Survey of Public Opinion," which verified the fact that the people look to the medical profession for guidance and action in the problem of complete distribution of medical care.

* * *

THE COUNCIL APPROVED the recommendation of its Medical Advisory Committee on Physical Rehabilitation that a uniform medical and surgical fee schedule, to apply to all governmental agencies, be adopted by the MSMS. A special committee to develop this schedule was appointed, which reviewed 25,000 items in 121 individual fee schedules. The Special Committee arrived at a Uniform Fee Schedule for Governmental Agencies which it felt was fair to all parties concerned. The House of Delegates approved the Schedule.

The 80th Annual Scientific Session of the MSMS, scheduled for Detroit, was cancelled. The War Committee on Conventions denied the request of the State Society to hold its Postgraduate Conference on War Medicine.

* * *

THE MICHIGAN FOUNDATION for Medical and Health Education was incorporated under the sponsorship of the MSMS. The purposes of the Foundation were "to acquire, provide, use, develop, endow, and finance methods, means, and facilities for postgraduate education in medicine, for lay health education, and for research fellowships and scholarships, all in such a manner as the Trustees shall determine." This replaces the MSMS Founda-



The Author
WILLIAM J. STAPLETON, JR., M.D.
MSMS Historian

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

tion for Postgraduate Medical Education, created in 1942.

— 1946 —

The February issue of THE JOURNAL took pride in claiming 14 "Firsts" for MSMS.

1. Plan for furnishing home office medical care for veterans.
2. Michigan Medical Service.
3. Extra-mural Postgraduate Education Courses in physician's own communities.
4. Michigan Foundation for Medical and Health Education.
5. Health Programs over WJR.
6. Annual Industrial Conferences.
7. Detroit-Denver Medical Public Relations Conferences.
8. Development of "outline" for needed medical legislation beneficial to the people.
9. Michigan Rheumatic Fever Control Program.
10. Medical Veterans' Readjustment Program.
11. Uniform Fee Schedule for Governmental Agencies.
12. Cancer Detection Clinics.
13. Organization of the Michigan Health Council.
14. Stimulation for creation of a National Health Congress.

* * *

THE FIRST annual Michigan Clinical Institute, sponsored by the MSMS in cooperation with the University of Michigan Medical School, the Wayne County Medical Society, and the U-M Department of Postgraduate Medicine, was planned for March 11-14, 1947.

Michigan Medical Service signed a contract with the Veteran's Administration to act as fiscal agent between the government and Michigan doctors who desire to render medical care to veterans. Michigan Medical Service adopted the Michigan Uniform Fee Schedules for Governmental Agencies for its payments.

The Council reorganized the Public Relations Committee with four sub-committees: Special Committee on Radio, Committee on Development of Literature, Committee on Distribution of Literature, and the Committee on the Cinema.



Andrew S. Brunk, M.D.
MSMS President, 1945-46



R. S. Morrish, M.D.
MSMS President, 1946-47

A newspaper advertising program, with 12 different ads prepared by the Public Relations Committee, was launched in newspapers throughout the State, inserted by the county medical societies.

Scientific radio presentations were aired by the MSMS and the University of Michigan Department of Postgraduate Medicine every Thursday over WJR.

* * *

THE OFFICE of Veterans Affairs adopted the Uniform Fee Schedule for Governmental Agencies, as of May 13, 1946. A spokesman praised the work done by physicians and declared that home-town care of veterans took the pressure away from the Veterans Administration hospitals at Dearborn, where all veterans previously were required to go for treatment.

The Michigan Health Council was busy organizing local community health councils.

The Annual Session held in Detroit broke all registration records. The final registration numbered 2,866 persons.

$250 Million Spent by Hospitals to Train Nurses

The operation of schools of nursing costs American hospitals an estimated $250 million a year, according to a report just issued by the National League for Nursing, New York.

In a six-year study on costs in nursing education, made under a grant from the U. S. Public Health Service, the league found that hospitals under public control spend more money to educate nursing students than do hospitals under private control. The report found that schools spend more on non-educational functions such as student maintenance than they do on educational functions.

The League researchers found also that (1) the median gross of educating one student for one year in a diploma nursing program is $2,600; the median net cost $2,300; (2) the median yearly income to the hospital per student to defray cost of the program is $250, and (3) the estimated value of the student's clinical experience to the hospital and other institutions in which she serves while learning nursing is $750.

Offer Eloise Booklet

An explanatory folder about the Wayne County General Hospital Psychiatric Division is available for interested physicians. A copy may be obtained from Sidney B. Jenkins, M.D., Directory, Psychiatric Division, Wayne County General Hospital, Eloise, 48132.

Summary of 1964 House of Delegates

This review of the proceedings of the 1964 House of Delegates of the Michigan State Medical Society in Detroit, September 20-22, represents the distillation of the deliberations of one hundred and fifty delegates. These delegates represent the fifty-five component county medical societies and their combined membership of nearly 7,000 Michigan doctors of medicine.

The resolutions, reports of committees and reference committees, and many other documents upon which the following actions were based is in the possession of the duly elected Delegates and those Alternate Delegates who attended and were seated.

If you require further information regarding any matter listed herein, any of these people, or the MSMS Headquarters in East Lansing, can provide you with additional details.

THE HOUSE OF DELEGATES ELECTED THE FOLLOWING OFFICERS AND COUNCILORS FOR THE COMING YEAR:

President-Elect.....Luther R. Leader, M.D., Birmingham
Speaker of the House.....James J. Lightbody, M.D., Detroit
Vice-Speaker of the House.....Louis F. Hayes, M.D., Gaylord
Councilor, 1st District (to 1967)..Edgar E. Martmer, M.D., Grosse Pointe
Councilor, 1st District (to 1967).....Don W. McLean, M.D., Detroit
Councilor, 1st District (to 1967).....Robert K. Whiteley, M.D., Detroit
Councilor, 4th District (to 1967).....Don Marshall, M.D., Kalamazoo
Councilor, 5th District (to 1967).....C. Allen Payne, M.D., Grand Rapids
Councilor, 6th District (to 1967).....Harold H. Hiscock, M.D., Flint
Councilor, 10th District (to 1965).....Edward H. Rodda, M.D., Bay City
Councilor, 14th District (to 1967).....Bradley M. Harris, M.D., Ypsilanti

Delegates to the AMA (two-year term):
Sidney Adler, M.D., Detroit
G. W. Slagle, M.D., Battle Creek
D. N. Sweeny, Jr., M.D., Detroit

Alternate Delegates to the AMA (two-year term):
Ralph R. Cooper, M.D., Grosse Pointe
O. B. McGillicuddy, M.D., Lansing
R. E. Ricc, M.D., Greenville

Alternate Delegates to the AMA to fill vacancies (terms expiring 1965):
Wyman C. C. Cole, Sr., Detroit
Otto K. Engelke, M.D., Ann Arbor

THE REFERENCE COMMITTEE REPORTS AND RESOLUTIONS RECEIVED THE FOLLOWING FINAL ACTION BY THE 1964 HOUSE OF DELEGATES:

A. MATTERS DEALING WITH GENERAL STATE SOCIETY BUSINESS:

1. Urged that all members of component medical societies encourage their spouses to become members of the Woman's Auxiliary to the Michigan State Medical Society.

2. Amended the Constitution of MSMS to include provision for a classification of non-resident members of the Society.

3. Amended the MSMS Bylaws to provide procedures for filling vacancies on The Council occurring at a time other than during an Annual Session of the Society.

4. Clarified what is meant by the term "emergency" in regard to the seating of Alternate Delegates in the MSMS House of Delegates.

5. Adopted a definitive clarifying statement of MSMS policy with respect to the relationship between doctors of medicine and doctors of osteopathy as regards (1) voluntary professional association, (2) admission of osteopathic physicians to hospital staffs, and (3) participation of individual osteopaths in MSMS, regional and local educational activities.

6. Amended the MSMS Bylaws to permit each established section of MSMS to elect one delegate-at-large with the right of the floor but without vote.

7. Changed the designation of the "Nervous and Mental" section of MSMS to "Psychiatry and Neurology" section.

8. Authorized the immediate establishment of a Judicial Commission, appointed by the President of MSMS, to both act as a review and advisory committee in matters concerning medical care and frequency of use and also to prepare recommendations providing for a permanent Judicial Board and System to become effective immediately following the 1965 Annual Session of MSMS. Also suggested a necessary change in the Constitution of MSMS for adoption in 1965.

9. Conferred Life Membership on all who serve as President, Chairman of The Council, or Speaker of the House of Delegates of MSMS.

10. Suggested adoption, in 1965, of a new name for the Michigan State Medical Society: Michigan Medical Association.

11. Conferred annual special expense allowance of $1,000 on the President of MSMS, the Chairman of The Council, and the Speaker of the House of Delegates.

12. Strongly urged support of all doctors of medicine of both the Michigan Doctors Political Action Committee and AMPAC.

13. Determined to press vigorously forward with plans to obtain financing for the Health Fair in Cobo Hall, Detroit, to highlight the 100th Anniversary of the Michigan State Medical Society in 1965.

B. MATTERS DEALING WITH THE COUNTY MEDICAL SOCIETIES:

1. Amended the Bylaws of MSMS to permit reduced MSMS dues to

Summary of House of Delegates, Continued:

physicians during their first year of practice even when county society exacts no dues.

2. Approved four suggestions for the guidance and control by private medicine of improved and enlarged emergency room care in hospitals and urged their consideration by all component MSMS county societies.

3. Urged all component societies to take every possible step to more fully implement the Kerr-Mills (MAA) Law at the local level.

4. Asked all county societies to urge their members to provide medical services for organized athletic programs.

5. Supported the principle of voluntary area-wide hospital planning where done by a committee on which physicians in private practice, appointed by the medical society involved, have adequate representation.

6. Urged all component societies to initiate counselling courses for careers in both medicine and the para-medical fields based upon information to be supplied by the Michigan State Medical Society.

7. Determined to re-charter all MSMS component medical societies with an appropriate ceremony as a part of the 1965 Centennial year celebration of the Society.

8. Reinstituted the annual award of "Michigan's Outstanding Physician" and directed that consideration be given to both professional and civic accomplishments.

9. Stated that boards of trustees of all private non-governmental hospitals in Michigan should be urged to consult with and obtain the approval of the medical staff by democratic nomination and/or election of all chiefs of staff, or services, prior to their appointment.

10. Encouraged and urged resumption of co-sponsorship of county medical societies and local health departments, and the support and cooperation of all physicians in the Michigan Diabetes Detection Program.

11. Urged initiation of active loan and scholarship programs on the part of all component county societies for medical students residing in, or coming from, such counties.

C. MATTERS RELATIVE TO COMMITTEES

1. Directed continuation of an advisory committee of the House to coordinate the House of Delegates with the MSMS Council's Centennial Committee.

2. Elevated all present scientific committees listed in the MSMS By-laws from their former status of subcommittees of the Public Health Committee to that of Standing Committees of the Michigan State Medical Society.

3. Redefined the composition of the MSMS standing committee on Public Health.

4. Redesignated the former committee on Geriatrics as the MSMS Standing Committee on Aging.

5. Called for continuation in 1965 of a Joint Committee on Medicine and Osteopathy, with members from the House of Delegates, The Council, and members-at-large, appointed by the President, to consider matters including possible future MD licensure of persons now licensed to practice as DOs in Michigan.

6. Directed development by the Committee on Constitution and By-laws of detailed criteria by which established MSMS sections may elect delegates-at-large to the MSMS House of Delegates, plus consideration of the new sections on Orthopedic Surgery and on Allergy and Applied Immunology.

7. Empowered the Committee on Rural Medical Service to explore establishment of preceptorships in community hospitals for observation by medical students of general practice, draft deferment for recent graduates' service in rural communities in urgent need of medical care, and promotion of more consultation services in rural community hospitals.

8. Recommended to the Scientific Radio and Television Committee exploration of video-taping its programs so that they might be reproduced for county societies not having live programs.

9. Directed appointment by The Council of a special committee to enhance coordination between private practice and public health services.

10. Directed the study by an appropriate MSMS committee of malpractice insurance, with a report to the 1965 House of Delegates regarding a possible MSMS company to provide same.

11. Directed establishment by an appropriate committee, of standards and procedures for classification and licensure by the State of Michigan of medical facilities for the care of subacute illness.

D. MATTERS DEALING WITH LEGISLATION AND GOVERNMENTAL AFFAIRS:

1. Directed that MSMS continue to work toward the ultimate goal of establishing in Michigan a single medical practice law.

2. Recommended effort to have information regarding tetanus immunization furnished by the Michigan Health Department sent with all issued drivers licenses, and urged that in the future drivers licenses carry the status of the licensee's tetanus immunization.

3. Assigned study of a proposed new General Court Rule in Michigan involving physician-patient relationship to the appropriate committee determined by The Council, MSMS.

4. Requested The Council to look into the entire matter of malpractice insurance coverage, its availability, rates, etc.

5. Requested the State Board of Registration in Medicine to answer specific questions regarding the adequacy of its present budget and legal powers of enforcement.

6. Approved federal government subsidization of elderly individuals having limited means in the private purchase of health insurance in the open market, with federally established minimum standards of financial responsibility and of benefits to be met by the involved insurance companies.

7. Directed that any necessary steps be taken to initiate state legislation to modify and improve Michigan's Medical Aid to the Aged (Kerr-Mills) program.

8. Stated that any medical educational policies of tax-supported medical schools should be estab-

Summary, Concluded:

lished only after consultation with organized medicine.

E. MATTERS CONCERNING PARA-MEDICAL AND ALLIED SUBJECTS:

1. Directed that the report entitled "Physician-Hospital Relations," prepared by the AMA Council on Medical Service's Committee on Medical Facilities, be made available to all hospital administrators in the State of Michigan by the Executive Office of MSMS.

2. Urged all physicians to encourage their employees to become members of the Michigan State Medical Assistants Society.

3. Directed establishment of a committee to assemble pertinent information concerning careers both in medicine and para-medical fields and to send the same to the county societies so that they can initiate counselling courses.

F. MATTERS DEALING WITH BLUE SHIELD AND PREPAYMENT PLANS GENERALLY:

1. Endorsed in principle the adoption of merit rating by Michigan Medical Service.

2. Directed The Council to appoint, by January 1, 1965, a fact-finding committee of physicians, without punitive powers, to evaluate utilization of prepaid medical services rendered in Michigan. Sources of information submitted to this committee are not to be identified as to physician or patient.

3. Adopted a policy that both the monetary unit value and the relative value for each field of medical practice (surgery, medicine, radiology and pathology) be considered separately and independently.

"Best in Show"

A water color by M. W. Jocz, M.D., Grosse Pointe Park, was declared "Best in Show" at the Annual Art Show for Michigan Physicians and their Wives in conjunction with the Annual Session in Detroit, September 22-23-24. His work was entitled "Snow Scene."



Oliver B. McGillicuddy, M.D., right, who was installed as President of MSMS for 1964-65 at Detroit, receives a gavel from Orlen J. Johnson, M.D., Bay City. The formal installation was before the State Society Dinner Dance during a short Annual Meeting of The Society.

Policy Explained Re Political Statements

After discussing the question of a member of MSMS making any statement for any political candidate, the MSMS Council's County Society Committee recommended that the MSMS President make a policy statement.

Following is an explanatory statement by Orlen J. Johnson, M.D., Immediate Past President:

"Candidates for or holders of political office frequently ask for the position of organized medicine on health issues. No health issue is as uncomplicated as it appears on the surface. An uninformed physician's opinion may be at variance with the attitude adopted by the organization after exhaustive study by committees. To misinform these people results in confusion and sometimes requires a great deal of unnecessary work to overcome unfavorable action.

"With the coming election we can only ask that all physicians call Michigan State Medical Society office for the official stand on any health issue. It will save embarrassment and work for us."

"Certificate of Commendation" Voted for Six

Six Michigan physicians were presented "Certificates of Commendation" at the House of Delegates for "Outstanding Contributions to Medicine in Michigan."

The MSMS House of Delegates voted the coveted awards to: Goldie B. Corneliuson, M.D., Lansing; John S. DeTar, M.D., Milan; Robert N. Heavenrich, M.D., Saginaw; Norman F. Miller, M.D., Ann Arbor; E. Gifford Upjohn, M.D., Kalamazoo, and Orus R. Yoder, M.D., Ypsilanti.

Pick Doctor Leader, President-Elect

Lightbody, Hayes Eight Councilors All Returned

Luther R. Leader, M.D., Birmingham, was elected at 12:02 a.m., Wednesday, September 23, by the MSMS House of Delegates as President-Elect of the Society. The election was unanimous.

Doctor Leader will take office in the fall of 1965 and serve during the MSMS Centennial year.

The Delegates unanimously re-elected James J. Lightbody, M.D., Detroit, as Speaker of the House, and renamed Louis F. Hayes, M.D., Gaylord, as the Vice Speaker.

Eight members of the MSMS Council were re-elected. Returned as Councilors for the 1st District were Edgar E. Martmer, M.D., Grosse Pointe; Don W. McLean, M.D., Detroit, and Robert K. Whitcley, M.D., Detroit.

Others elected for full three-year terms were Don Marshall, M.D., Kalamazoo, 4th District; C. Allen Payne, M.D., Grand Rapids, 5th District; Harold H. Hiscock, M.D., Flint, 6th District, and Bradley M. Harris, M.D., Ypsilanti, 14th District. Incumbent Edward H. Rodda, M.D., Bay City, was elected to fill a term expiring in 1965.

Sidney Adler, M.D., Detroit, was elected a Delegate to AMA and renamed as Delegates were George W. Slagle, M.D., Battle Creek, and D. N. Sweeny, Jr., M.D., Detroit. Chosen as Alternate Delegates for 2-year terms were Ralph R. Cooper, M.D., Detroit; Oliver B. McGillicuddy, M.D., Lansing, and Robert E. Rice, M.D., Greenville.

Elected as Alternate Delegates to terms expiring in 1965 were Otto K. Engelke, M.D., Ann Arbor, and W. C. C. Cole, Sr., M.D., Detroit.

Terms of the Delegates and Alternate Delegates will begin January 1, 1965. The current delegation of the AMA will serve through the November AMA meeting in Miami.



"Congratulations" are exchanged between two men elected by the MSMS House of Delegates. James J. Lightbody, M.D., left, Detroit, was unanimously renamed Speaker of the MSMS House of Delegates, and Luther R. Leader, M.D., right, Birmingham, was unanimously chosen as President-Elect. Doctor Leader will be installed at the 1965 Centennial Session in Detroit.

Doctor Hiscock To Continue to Lead Council

Harold H. Hiscock, M.D., Flint, was elected September 24 by members of The MSMS Council to serve as Chairman for his second term.

In the organizational meeting of The Council, Robert J. Mason, M.D., Birmingham, was re-named Vice-Chairman.

Bradley M. Harris, M.D., Ypsilanti, was chosen to continue as chairman of the Publication Committee. C. Allen Payne, M.D., Grand Rapids, again heads the Finance Committee. Ross V. Taylor, M.D., Jackson, is the new chairman of the County Societies Committee. Edgar E. Martmer, M.D., Grosse Pointe, declined nomination for another term as County Societies chairman.

The membership of The Council for 1964-65 will remain the same as the past year, following the re-election September 22 of six councilors by the House of Delegates.

Mental Health AID Newsletter Offered

Designed to be of both general and technical assistance to physicians, the first issue of a new publication, "A I D," has been distributed to over 300 physicians and lay mental health leaders throughout Michigan by the MSMS Mental Health Committee.

"A I D" (Advice, Information, and Data) issue No. 1, which contains complete background on the new Michigan community mental health services law and the law itself, also incorporates a section of specific psychiatric information prepared by the MSMS Mental Health Committee for reference by physicians.

MSMS Offers PG Programs

The annual Fall MSMS Postgraduate Education Extramural Programs will begin October 6 at Battle Creek.

Under the direction of the MSMS Postgraduate Education Committee, 10 programs will be held in the Lower Peninsula and nine in the Upper Peninsula, according to John M. Sheldon, M.D., Ann Arbor, committee chairman.

The MSMS Committee advanced plans for the fall programs when it met in August at the MSMS Headquarters. The Committee is hopeful to continue its experimentation in efforts to improve the postgraduate work, and will have more new features for the spring events.

In 1963, the fall series drew 608 doctors.

A brochure listing all the speakers and their topics will be sent to every MSMS member. Anyone wishing detailed information may write to the MSMS Postgraduate Education Committee, MSMS, 120 West Saginaw, East Lansing.

The following calendar is organized chronilogically:

Lower Peninsula:

October 6 —Battle Creek
October 16—Muskegon
October 20—Lansing
October 20—Niles
October 29—Alpena
November 12—Grayling
November 12—Midland
November 12—Petoskey
November 17—Jackson
Date to be set—Traverse City

Upper Peninsula:

October 19—Sault Ste. Marie
October 20—Escanaba
October 20—Manistique
October 20—Ironwood
October 21—Calumet
October 21—Menominee
October 22—Iron Mountain
October 22—Marquette
Date to be set—Ontonagon

* * *

Honor Two Employees

Two MSMS employees were honored by the 1964 House of Delegates as part of an authorized program to recognize years of service.

This year, the Delegates applauded the presentation of a 10-year award to Warren F. Tryloff and a 5-year award to Herbert A. Auer.

AMA Enlists Teachers, Others As Affiliate Members

The American Medical Association has broadened its category of affiliate membership to encourage enrollment of physicians, teachers of medicine, scientists not otherwise eligible to join, dentists, and pharmacists.

County and State medical societies have been urged by the AMA to encourage eligible persons in this category to join the AMA, particularly the teachers and scientists. Affiliate memberships for these persons would encourage support of AMA programs and improve relationships with medical colleges.

CALENDAR OF COMING EVENTS

October 15-17—University of Michigan Medical Center Alumni Conference, Ann Arbor.

October 16—Hospital Section of Michigan Library Association, Jack Tar Hotel, Lansing.

October 21-22—Michigan Tuberculosis and Respiratory Disease Association and the Michigan Thoracic Society, Statler-Hilton Hotel, Detroit.

October 18-24—"Michigan Community Health Week"

November 5—South Western Michigan Clinic Day, Battle Creek.

November 11-12—Michigan Academy of General Practice, Annual Fall Postgraduate Clinic, Sheraton-Cadillac Hotel, Detroit.

November 13-16—National Society for Crippled Children & Adults, Statler-Hilton Hotel, Detroit.

November 14-15—Michigan Allergy Society, Midwest Forum on Allergy, Henry Ford Aud., Detroit.

December 16-18—Michigan Department of Health, Epidemiology Conference, Jack Tar Hotel, Lansing.

1965

Feb. 22-26—Canadian-American Medical and Dental Ski Ass'n, Boyne Highlands, Harbor Beach.





Offer Emergency Medical Identification Cards

With the adoption by the AMA of the universal medical alerting symbol shown above, the American Medical Association prepared a wallet-sized emergency medical identification card to be carried by persons with conditions which could be aggravated by accident or by incompatible medication.

The MSMS now makes these Emergency Medical Identification Cards available for members to issue to patients needing them.

MSMS also offers an educational brochure for use in the office.

A mailing was made in September to every MSMS member with an order form. If you have not returned yours, or have mislaid it, then just write to MSMS for an initial supply. Additional supplies are available as you need them.

The American Medical Association, on the advice of its Committee on Emergency Medical Identification, developed the symbol which it offers for use on all emergency medical identification signal devices and identification cards. It is the hope of the AMA that it will become the universal lable of emergency information.

It is intended to supplement rather than replace the identifying symbols presently distributed by various organizations and agencies, the AMA explains. A list of firms using the symbol on various medallions, etc., was sent to every MSMS member with the order form. The MSMS Public Relations Committee recommended this approach to the Council, leaving the particular device a choice for every doctor to make.

The MSMS project has been supported by the House of Delegates, The Council, and the Public Relations Committee. A House resolution supported the idea by pointing out, in part, that "the knowledge of the type of illness which a patient may have and the medication which he is taking is of utmost importance in an emergency situation."

The AMA Department of Health Education has urged,

"We hope that all medical associations will join us in the promotion of this symbol as the universal indicator of the presence of emergency identification. We also hope you will join in the wide distribution of the new Emergency Medical Identification Cards which can be a valuable supplement to many of your public service programs."

The symbol on the card or displayed on a wristlet, an anklet, a medallion around the neck or elsewhere will be a sign that there are vital medical facts on a personal health information card in the bearer's purse or wallet or on an alerting device.

The symbol is a hexagon-shaped emblem containing a six-pointed figure, or sign of life. Superimposed on the figure is a staff with a snake entwined about it—the staff of Aesculapius.

Michigan PTA's to Help Sponsor Self-Help Courses

The Michigan Congress of Parents and Teachers at its convention adopted 18 resolutions—including two of direct interest to county medical societies and doctors.

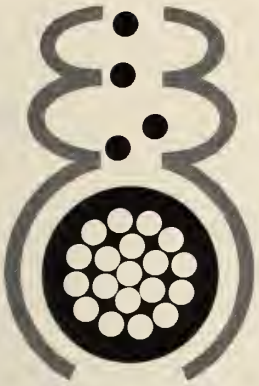
During the coming year, the 400,000 PTA members in Michigan will be urged "to help sponsor the Medical Self Help courses prepared primarily to enable families to meet emergency situations during natural disasters or wartime conditions." In many communities, PTA units work with school officials, county medical societies and allied groups to offer such courses to the general public and also to high school students.

PTA units and members also were urged to join in studies of community mental health needs. Most PTA units have health and/or mental health committees.

Other resolutions dealt with various aspects of education, child welfare, safety, recreation, and other subjects related to better homes, schools and communities.

Herbert A. Auer, of the MSMS staff, is secretary of the Michigan Congress of Parents and Teachers.

(Turn to Page 726)



LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

- lowers motility promptly
- relieves spasm promptly
- stops diarrhea promptly

Lomotil fulfills the first order of treatment in most patients with diarrhea — prompt symptomatic control.

Pending discovery of the cause, early cessation of diarrhea is almost always urgently indicated. Prompt symptomatic control averts distress, dehydration and, frequently, severe exhaustion.

Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE
Research in the Service of Medicine

45 Physicians Awarded Coveted 50-Year Pins

One of the highlights of the 1964 House of Delegates meeting was the presentation of the coveted "50-Year Pin" to 45 members of the Michigan State Medical Society.

The physicians able to attend the Detroit meeting received the pins on Tuesday morning, September 22, before the applauding delegates. The pins will be mailed to the men who were not able to be present. Following the ceremony, the physicians enjoyed a luncheon and the opportunity to reminisce about their early days of practice and about the many changes they have seen in the half-century.

Following is the list of awardees:

Calhoun County
R. H. Baribeau, M.D., Battle Creek
Carl G. Wencke, M.D., Battle Creek

Cass County
S. L. Loupee, M.D., Dowagiac
F. L. Pierce, M.D., Dowagiac

Clinton County
W. B. Fillinger, M.D., Ovid

Ingham County
Milton Shaw, M.D., Lansing

Kent County
David B. Hagerman, M.D., Grand Rapids

Monroe County
Clarence D. Barrett, M.D., Monroe
Reginald W. McGeoch, M.D., Monroe

Macomb County
A. B. Bower, M.D., Armada

Oakland County
Frank A. Mercer, M.D., Birmingham
John K. Ormond, M.D., Pontiac

Wayne County
Herbert C. Allison, M.D., Detroit
Stilson R. Ashe, M.D., Detroit
L. Byron Ashley, M.D., Fort Lauderdale, Florida
Carl C. Birkelo, M.D., Winter Park, Florida
Ladislaus Bogusz, M.D., Leisure City, Florida
Audrey O. Brown, M.D., Pleasant Ridge
Dudley W. Byers, M.D., Detroit
George L. Caldwell, M.D., Detroit
Malcolm D. Campbell, M.D., Detroit
Aaron L. Chapman, M.D., Pensacola, Florida
Clarence M. Clark, M.D., Detroit
Harold E. Clark, M.D., Southfield
Lyman W. Crossman, M.D., Detroit
Ira G. Downer, M.D., Detroit
Samuel J. Eder, M.D., Detroit
Herbert E. Fogt, M.D., Detroit
R. John Hardstaff, M.D., Grosse Pointe
Arthur B. Henderson, M.D., Detroit
Leslie T. Henderson, M.D., Detroit
J. Stewart Hudson, M.D., Grosse Pointe
Bror H. Larsson, M.D., Detroit
Arlington F. Lecklider, M.D., Grosse Pointe
Harry Lewin, M.D., Detroit
Orlando W. Pickard, M.D., Detroit
Harry C. Saltzstein, M.D., Detroit
Simon H. Sauter, M.D., Detroit
Arthur E. Schiller, M.D., Detroit
J. G. Slaughenhaupt, M.D., Detroit
Eugene Steinberger, M.D., Detroit
Albert M. Wehenkel, M.D., Detroit
David Weingarden, M.D., Detroit
Gerald A. Wilson, M.D., Detroit

Legislative Appropriations Increased for 1964-65

A total of $57.4 million was authorized for capital outlay building programs for 1964-65 by the 1964 session of the state legislature. This represents an increase of $23.4 million over the preceding year. Some of the capital outlay appropriations of special interest to MSMS members are the following:

Authorization of $6.56 million, almost double last year's appropriation, for building and improvements in Michigan's mental health facilities, including,

—$400,000 to complete construction of a day school building and an 18-bed addition to the Hawthorn Center in Northville.

—$670,000 to complete construction of a $1.5 million Research wing to the Lafayette clinic facility in Detroit.

—$786,500 to complete construction of a $1.3 million, 200-bed facility for toddlers at the Plymouth State Home and Training School.

—$500,000 to start construction of a new 80-bed children's unit at the Pontiac State Hospital.

—$600,000 to start construction of a 110-bed building for physically handicapped at Plymouth State Home and Training School.

* * *

Authorization of a record $32.55 million for building and improvements in Michigan's facilities for higher education, including,

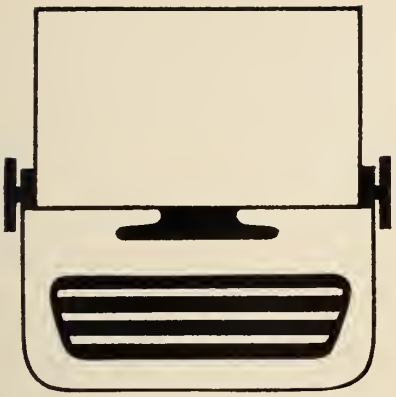
—$500,000 to continue a $3.8 million project of renovation of the medical center facilities at the University of Michigan.

—$2.75 million to complete construction of a $6 million chemistry building at Michigan State University.

—$1.8 million to complete construction of a new $3.4 million physics building at Wayne State University.

—$176,000 to complete the construction of a $2.7 million science building at Central Michigan University.

—$750,000 to start construction of a $3 million science building at Northern Michigan University.



EDITORIAL VIEWS

Strep Culture Saves Lives

There is an article appearing elsewhere in this journal by Dr. Preston which focuses interest on throat culture as a vital step in the adequate treatment of streptococcal pharyngitis and subsequent rheumatic fever prevention.

There are perhaps 20,000 new cases of acute rheumatic fever reported in the United States annually. This number is staggering when one stops to think that acute rheumatic fever is a completely preventable disease.

With other infectious diseases including polio, diphtheria, whooping cough and measles now under control, it seems an appropriate time to focus attention on rheumatic fever prevention. A three-prong attack on this childhood crippler is necessary to eradicate the disease from our population, *viz.*, parent education, physicians education and laboratory education.

Parents must be made aware of the possible complications of acute sore throat or tonsillitis. In this day of overburdened medical practice this would appear to be putting another straw on the camel's back. However, time must be made for this type of patient, perhaps at the expense of seeing patients with lesser illnesses. The small additional cost of adequate bacteriologic diagnosis should be acceptable to the general public, witness the wide acceptance by the laity of the vaginal pap in cervical cancer prophylaxis. In fact, throat culture in the long run would cut patient cost by allowing the physician to selectively treat streptococcal infections and withhold unnecessary antibiotic treatment of non-bacterial pharyngitis.

The most important link in the educational program is physician education. We must go back to the medical school level and re-educate the young physician and the young pediatrician regarding the value of throat culture.

It has been well established that a clinical diagnosis of streptococcal pharyngitis is virtually impossible. In this era of sophisticated diagnostic procedures with the utilization of all the physical sciences such a simple and time-honored procedure as throat culture may seem mundane. However, all too often we hear the young physician talk about pneumococcal pharyngitis, staphylococcal tonsillitis, antibiotic sensitivity testing of normal flora.

With the disappearance of diphtheria from our population only Group A beta-strep remains as a cause of bacterial infection in older children and adults. The problem of Hemophilus infection is specifically confined to infants and should be dealt with separately and individually.

Laboratory directors and clinical bacteriologists must come down from their ivory towers. Instead of being taxonomists and meticulously identifying all of the species and subspecies of normal flora, they must focus attention on the only serious pathogen in the throat, namely, the Group A beta-hemolytic strep.

Perhaps some of the confusion that has occurred on the evaluation of throat cultures and subsequent rejection of these as a diagnostic tool has been the fault of the microbiologist who insists on this endless reporting of useless data. The bacteriology laboratory has become updated with the advent of immunofluorescence as a diagnostic tool. Group A streptococcal infection can now be diagnosed with accuracy in a matter of hours.

There is no reason why any child should have adequate therapy withheld in streptococcal pharyngitis for want of an adequate bacteriologic diagnosis.

These points are well brought out in the recent study by Dr. Jeremiah Stamler in conjunction with the Chicago Board of Health. He reviewed 110 cases of acute rheumatic fever; 95 per cent of those children had a history of acute respiratory

infection within five weeks prior to attack. Only 50 per cent of these sought medical attention. Of those seeking medical attention, only 27 per cent had throat cultures, a third of which were positive for betahemolytic strep, but in only one instance was the streptococcus specifically grouped.

These data certainly demonstrate defects on the part of physician, parent and laboratories in carrying out a program for the prevention of rheumatic fever. In these days of preventive medicine all three groups need updating.

Bodies, Minds and Souls

By Richard Rapport, M.D., Flint, Chairman, MSMS Committee on Medicine and Religion

The physician and the clergyman are dedicated to a common task—the healing of bodies, minds and souls. Yet, members of the two professions seldom join forces to provide the best possible care for the patient-parishioner.

In September of 1961 the American Medical Association, aware of this problem, established a Department of Medicine and Religion under the outstanding leadership of the Rev. Dr. Paul McCleave. An Advisory Committee was appointed by the Board of Trustees of the American Medical Association to help formulate goals and methods to achieve them. In the fall of 1962, a group of 20 county medical societies were selected to conduct pilot programs designed to bring together physicians and clergymen. Varying programs were explored and evaluated at the local level in an effort to promote the desirable liaison between the two professions.

Approximately one year ago, the MSMS Council appointed a Committee to implement such a program in Michigan. County society committees have subsequently been established in the larger population areas where programs are being developed. Expansion to include all county societies in Michigan is anticipated.

Response by the medical profession, by the clergy, and especially by the patient, has indicated that a vital need exists for better understanding. Problems are concerned with such diverse and vital areas as life and death, adjustment to deformities and disabilities, suicide, terminal illness, psychological disturbances and prevention of unwarranted lawsuits. There are no black and white answers to the decisions involved, since each illness, each patient, each family and, indeed, each doctor and each minister present unique situations. It is imperative that every problem be dealt with within the scope of its peculiar circumstances.

The average family places such confidence in its clergymen as well as in its physician that consultation between the two should be the rule rather than the exception. Resultant from such consultations should come collective judgments to provide for the most effective care and treatment of the patient as a whole man.

Your state committee is anxious to assist in the organization of county committees and to suggest methods to achieve the desired goals. Once established each committee should design programs adapted to their peculiar circumstances, since varying local conditions mitigate against state and national direction. The possibilities are unlimited and the benefits to be gained invaluable for the doctor, for the clergyman, for the community, and, especially for the patient.

Community Health Week

By Norman A. Welch, M.D.,*
AMA President

America will mark the second observance of Community Health Week next October 18-24. State, county and local medical societies and allied health groups across the land will join in planning and presenting community activities appropriate to the occasion.

We have a story to tell—a remarkable story of enormous progress in the health field and of the new achievements and conquests that are occurring, step by step, almost daily.

We urge all of you to invite both public and private health agencies to participate in Community Health Week and to be your full partners in developing the most appropriate local program for the observance. Community Health Week should represent an outstanding demonstration of

*Doctor Welch, who wrote this editorial in late August, died unexpectedly September 3 while on a speaking tour in Colorado.

cooperation between the medical profession and community health agencies.

The primary goal of Community Health Week, as envisioned by the House of Delegates of the American Medical Association in authorizing the program at its 1962 Clinical Convention in Los Angeles, is to focus public attention, at the community level, on the health progress and medical advances that have been made. The accent should be on the quality of each community's health services and facilities.

By dramatizing the fact that existing medical and health services are the fruits of community teamwork and planning in past years and stressing that it is the responsibility of each citizen, working with his neighbors, to help plan now for tomorrow's needs, Community Health Week can serve as an inspiring guide to community action.

Yamasaki Cited Again

Newest honor won by Minoru Yamasaki, architect for the MSMS headquarters, is the "Horatio Alger Award" presented recently in New York. Ten Americans received the award given to those "of humble background who achieved success in his chosen field."

Not Here in America

Since the Declaration of Independence, many of us have forgotten the value of freedom and how relatively easy it is to lose it. For many years, carping critics have been pointing out so-called weaknesses of private enterprise without pointing out its virtues. For a generation, too many of our people have been influenced by insidious propaganda to depend on government instead of relying upon their own initiative.

We have been told, as if it were a new idea, that a government-controlled economy would bring more benefits to the people. And this is claimed despite the fact that there is nothing new in government-planned or controlled economy; human beings have lived under various forms of that kind of so-called social and economic security for thousands of years.

The price they paid was persecution, poverty, misery and loss of religious, political and individual freedom. We must not let that happen here in America.

—Donald J. Hardenbrook, *Chairman*,
NAM Executive Committee,
In Commencement Address
At Detroit Institute of Technology

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Say you saw it in Michigan Medicine

THE DERMATOSES THAT WERE STEROID-UNTREATABLE

Salt and water retention, edema, overstimulation of the appetite, excessive weight gain, mood swings—these were some of the problems that used to confront physicians when they wanted to prescribe steroids for dermatoses. For patients already overweight, or with edema associated with cardiovascular disease, or those who were tense and anxious, steroid treatment could aggravate their problems. But with the advent of ARISTOCORT® Triamcinolone, many of these patients became "steroid-treatable." The reason: Not only did *this* steroid provide gratifying symptomatic relief, but it did so *without* the penalty of overstimulation of the appetite, excessive weight gain, salt and water retention, edema, and undesirable euphoria. And these benefits have been confirmed for other patients with steroid-susceptible disorders, as well as those formerly untreatable.



Side Effects: Since it may, under some circumstances, produce many of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.
Contraindications: While the only absolute contraindications are tuberculosis, herpes simplex and chicken pox, there are some relative contraindications (peptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.
A single daily dose may provide effective control, is convenient for the patient, and can be employed in both initial and maintenance therapy.

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PUBLIC RELATIONS

Kalamazoo Polio Excess Given to Hospitals

Checks for $70,470 were given recently by The Kalamazoo Academy of Medicine to two hospitals. The money represented the excess funds collected by the Academy at the oral polio vaccine clinics. The academy gave $66,242 to the Borgess-Bronson Hospitals fund drive and $4,228 to the Franklin Memorial Hospital at Vicksburg.

In the past four years, has there been an increase in the number of physicians registered in your county? A decrease? Or has there been virtually no change?

The answers to these questions are provided in a study of the following statistical information from the Michigan State Board of Registration in Medicine. (The 1964 re-registration figures are from the Board report as of March 13).

It's Up to You

If you don't like the things your county medical society is doing, the only real way to correct it is to get out and work for the stand you feel is more desirable. The same is true for the state and national organization.

Too many doctors for too many years have sat in their office chairs or in the hospital coffee room, and complained about the "old grey heads misrepresenting the membership" but they are too busy to help when the society needs their services.

Often the situation we grouse about is the one we understand the least. The more you work for the society, the better you understand the way it works, and why certain decisions are being made.

The most deplorable problem at the present, is the lack of assistance from many of our young physicians. They seem to feel that their efforts would go unappreciated and because of this erroneous thinking, do not display an interest in the society's activities.

—Excerpts from Editorial
By Donald R. Byrant, M.D.,
In September *Genesee County Medical Society Bulletin*

PR Seminar Suggests Eight Basic Projects For County Societies

Eight major areas of county society public relations activities were stressed at the 1964 AMA Public Relations Seminar in Chicago.

"Projects in each of these areas are designed to meet an important PR need in the county and eliminate sources of criticism by the public," the speakers pointed out. "Activity in each area ultimately will cement good relations between doctors and the public."

The eight recommended PR activities for every county society were:

1. *Provision of emergency medical care on a round-the-clock basis.*
2. *Establishment of a grievance committee to hear patient's complaints.*
3. *Development of good working relations with press, radio and TV people.*
4. *Maintenance of an active speakers bureau supplemented with other health educational activities.*
5. *Organization and promotion of a plan to provide medical services to all who cannot pay for them.*
6. *Orientation programs for new society members.*
7. *Initiation of public service projects.*
8. *Participation in citizenship activities.*

The Seminar also stressed the importance of membership participation as essential. Panel speakers for this topic included C. J. Tupper, M.D., President, Washtenaw County Medical Society.

Kent County was represented at the Seminar by J. Russell Brink, M.D., President; William Haeck, M.D., President-Elect, and William McClimans, Executive-Secretary.

Muskegon County was represented by William J. Hanley, M.D., and F. James Stubbart, M.D.

Genesee County was represented by Mrs. Ruth Garnsey, Executive Secretary.

Representing the MSMS staff was Hugh W. Brenneman, Executive Director, M. A. Riley and Herbert A. Auer.

A special meeting was held in conjunction with the Seminar for state society presidents and presidents-elect, and Orlen J. Johnson, M.D., and Oliver B. McGillicuddy, M.D., both participated.

Speaks to Welfare Officials

Orlen J. Johnson, M.D., filled one of his last official acts as a speaker at the Annual Convention of the State Association of Welfare Boards and Directors at Harbor Springs.

Says Medicine Needs Maximum Support Of Every Physician

"Medicine has a rich past, enjoys a vigorous present, and can play a great role in tomorrow."

That statement was made in a recent address by F. J. L. Blasingame, M.D., Executive Vice-President of the AMA. He then went on to add:

"As man cleans the cobwebs of confusion, fear, and ignorance from the mind, a sense of value of health is coming upon the scene in human affairs. Health speaks a universal language: individually to each of us and collectively to all of us."

Doctor Blasingame continued: "The public appetite for the fruits of modern medicine has become almost insatiable, not only in our nation but also in much of the remainder of the world. This rising surge in expectations in the health field can be labled as one of the most significant social developments of our lifetime. The people of the world want more of life, including better health; they want a more abundant life. This great awakening, accelerated by developments in communications and transportation, is a force for good—a laudable happening in which we should all rejoice.

* * *

"A HEALTHY SOCIETY is a free society. It is marked by a high degree of individual responsibility and self-discipline. Compulsion is evidence of personal and social illness. The great profession of medicine cannot accept any other viewpoint in promoting a healthy, more abundant life for all mankind."

Continuing, Doctor Blasingame said, "Through the American Medical Association and the constituent societies, the individual physicians speak with a single, strong voice on a wide variety of national and local matters affecting the public health. Through the AMA and the state and county medical societies, physicians develop and carry out countless programs for the improvement of the profession and the betterment of the public health. These accomplishments, for the most part, would be impossible for the individual physician acting alone.

* * *

"THE AMA IS ONLY as strong as its constituent societies. Its strength flows upward from them. It is, therefore, desirable that all physicians take an active part in the affairs of their county and state organizations. Medicine cannot remain free to fulfill its destiny without a strong organizational structure, and its organizational strength depends on maximum support and participation by members of the profession."

(These are the excerpts from an address by Doctor Blasingame before the State Medical Society of Wisconsin.)

COMING IN FUTURE ISSUES

WATCH FOR these and other timely and informative articles scheduled to appear in coming issues.

Cervical Spine and Spinal Cord Injuries

By Richard C. Schneider, M.D., Ann Arbor. Dr. Schneider presents a number of case reports with illustrations and important observations of value to every physician.

The Clinical Significance of Cutaneous Xanthoma

By Jules Altman, M.D., and Coleman Mopper, M.D., Detroit. Presenting a classification of xanthoma and describing the diagnosis based upon studies of serum lipid values.

Rupture of the Uterus

By D. C. Swan, M.D., Southfield. A case report of ligation of the internal iliac artery as a life-saving procedure in uterine rupture.

The Hyperkinetic or Lethargic Child with Cerebral Dysfunction

By S. J. Nichamin, M.D., and H. M. Comly, M.D., Detroit. A pediatrician and a psychiatrist join hands to discuss behavioral disorders, their relationship to educational achievement and the use of newer psychopharmacological drugs.

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Argo Pure Corn Starch the Ideal Baby Powder



ARGO HANDY-PACK It's the ideal plastic dispenser for dusting powder on babies. By squeezing the sides, the new Handy-Pack puffs out the exact amount of Argo required. Easy to use, the Argo Handy-Pack is reusable, too. Just remove cap and refill from the yellow and blue Argo packages to have a permanent, economical dusting powder dispenser.

ARGO CORN STARCH Argo Corn Starch is safer than ordinary baby powder because it contains no abrasives. Argo Corn Starch dries up moisture . . . soothes irritating rash and chafed skin. And Argo leaves a velvet-smooth film on skin to guard against further irritation. Argo in the new plastic Handy-Pack is pure corn starch in its most convenient form.



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available as the new individually-capped unit, boxes of 5, or in cartons of 25

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Say you saw it in Michigan Medicine

ANCILLARY SECTION

MHC Placements

Recent placements by the M.D. Placement Service have included the following: Alfred R. Neruda, M.D. (Algonac); Robert Sealby, M.D. (Reed City); Howard J. Sawyer, M.D. (Ford Mtr. Co., Dearborn); John F. Kenney, M.D. (Gladwin Hosp., Gladwin); B. G. Keizer, M.D. (Newberry St. Hosp., Newberry); Robert M. Watson, M.D. (Jackson & Milford); Ramon D. Turman, M.D. (Redford Med. Ctr., Det.); Eugene P. O'Donnell, M.D. (Lansing); Donald F. Nagler, M.D. (Mt. Pleasant).

Radio Editorials Laud Coller-Penberthy Conference

During the recent Annual Coller-Penberthy Medical Conference at Traverse City, station WTCM aired two "radio editorials" about the outstanding postgraduate project.

The radio station traced the history of the Coller-Penberthy conferences since 1921. The announcer then went on to point out that "A few years ago, this postgraduate teaching program was formally designed as the Annual Coller-Penberthy Medical Conference, honoring two of its greatest sponsors. Dr. Edwin L. Thirlby, the major stimulant to the continuation of this annual meeting, has always tried to remain in the background, insisting that credit for accomplishments be given to others. But it was at his insistence that the sociability aspect of the meetings has been kept, as he felt it was important in developing an atmosphere of intimacy and friendship.

"The conference leaders, over the years, have observed a progressive increase in medical knowledge and techniques and the results of their daily use in the care of patients, until now the Traverse City region is becoming known as one of the great medical centers of the state. This reputation is not confined to the city itself, but extends to and includes all the rural practitioners of the region. Without question, the Annual Coller-Penberthy Medical Conference is a major contribution to the present high standard of medical care which the people of the Traverse City area receive."



The photo above of speakers for the Coller-Penberthy Conference was made available by the *Traverse City Record Eagle.*

Left to right (*standing*): A. James French, M.D., Ann Arbor; Marion S. DeWeese, M.D., Columbia, Missouri; Mark A. Hayes, M.D., New Haven, Connecticut; Merle M. Musselman, M.D., Omaha; G. Thomas McKean, M.D., Detroit; Clifford D. Benson, M.D., Detroit; Joseph W. Hess, M.D., Detroit; Donald R. Korst, M.D., Ann Arbor; Harry A. Towsley, M.D., Ann Arbor; John M. Sheldon, M.D., Ann Arbor; Isadore Lampe, M.D., Ann Arbor; (*seated*) Fred J. Hodges, M.D., Ann Arbor; Carl E. Badgley, M.D., Ann Arbor; Edwin L. Thirlby, M.D., Traverse City; Orlen J. Johnson, M.D., Bay City; Arthur C. Curtis, M.D., Ann Arbor; Albert C. Furstenberg, M.D., Ann Arbor; Edgar Kahn, M.D., Ann Arbor; Reed M. Nesbit, M.D., Ann Arbor; Absent at the time the photograph was taken: Lester R. Dragstadt, M.D., Gainesville, Florida; C. Gardner Child, III, M.D., Ann Arbor; Richard J. Bing, M.D., Detroit; William Reveno, M.D., Detroit; William N. Hubbard, Jr., M.D., Ann Arbor; William A. Altemeier, M.D., Cincinnati.

Wayne Offers Conference On Crash Injuries

Wayne State University in co-operation with the University of Minnesota and the University of California will sponsor the Eighth Stapp Car Crash Conference October 21-22-23, dedicated to increasing automotive safety and decreasing injuries and deaths from accidents. Demonstrations of actual crashes and crash simulators as used in safety research together with presentation of results of original research in crash safety will highlight the conference.

The conference will open October 21 at the Ford Motor Company at Dearborn, then move October 22 to Wayne State, and October 23 to the General Motors Proving Grounds at Milford.

Epidemiology Conference Set in Lansing, Dec. 16-18

The Michigan Department of Health announces an Epidemiology Conference to be held at the Jack Tar Hotel, Lansing, December 16, 17, 18.

Outstanding nationally-known speakers will speak on the subjects of rabies, tuberculosis, the venereal diseases and the epidemiology of accidents. The conference will also include a seminar on Salmonella and such topics as A New Rabies Vaccine for Human Prophylaxis and Rabies Prophylaxis in Man. The speakers and topics and further details will be included in the November issue of MICHIGAN MEDICINE.

Readers Write

Dear Dr. Tupper:

Thank you for calling our attention to the omission of a credit line for your journal with the article, "Physical Status of Interns and Resident Physicians at Wayne County General Hospital 1962-63," which we published in the August issue of *The New Physician*.

It certainly was our intention to give full credit, and we intend to run a statement regarding the matter in the October issue of our journal.

Sincerely,
JEAN VAN GERPEN (MRS. GEORGE)
Managing Editor
The New Physician

* * *

"Congratulations on your new format; it is most attractive. The entire magazine looks new and fresh and very interesting."

FRANK B. RAMSEY, M.D.
President,
State Medicine Journal Advertising Bureau



This candid picture, made during The University of Michigan Medical School's third annual Hospital-Internship Day, shows representatives of Michigan hospitals discussing their internship programs with U-M medical students.

U-M Juniors Join Seniors For Internship Day

Ninety-nine doctors representing 30 Michigan hospitals were on hand for The University of Michigan's third annual Hospital-Internship Day at the Medical Center in Ann Arbor.

After hearing welcoming remarks by William N. Hubbard, Jr., M.D., dean of the U-M Medical School, Harry A. Towsley, M.D., professor of pediatrics and associate director of the Department of Postgraduate Medicine, and Arthur Fleming, president of the Senior Class, the physicians discussed their hospitals' internship programs with U-M medical students.

This year—for the first time—members of the Junior Class, as well as the Senior Class, participated in the activities.

Doctors Clifford, Swanson Direct Ob-Gyn Society

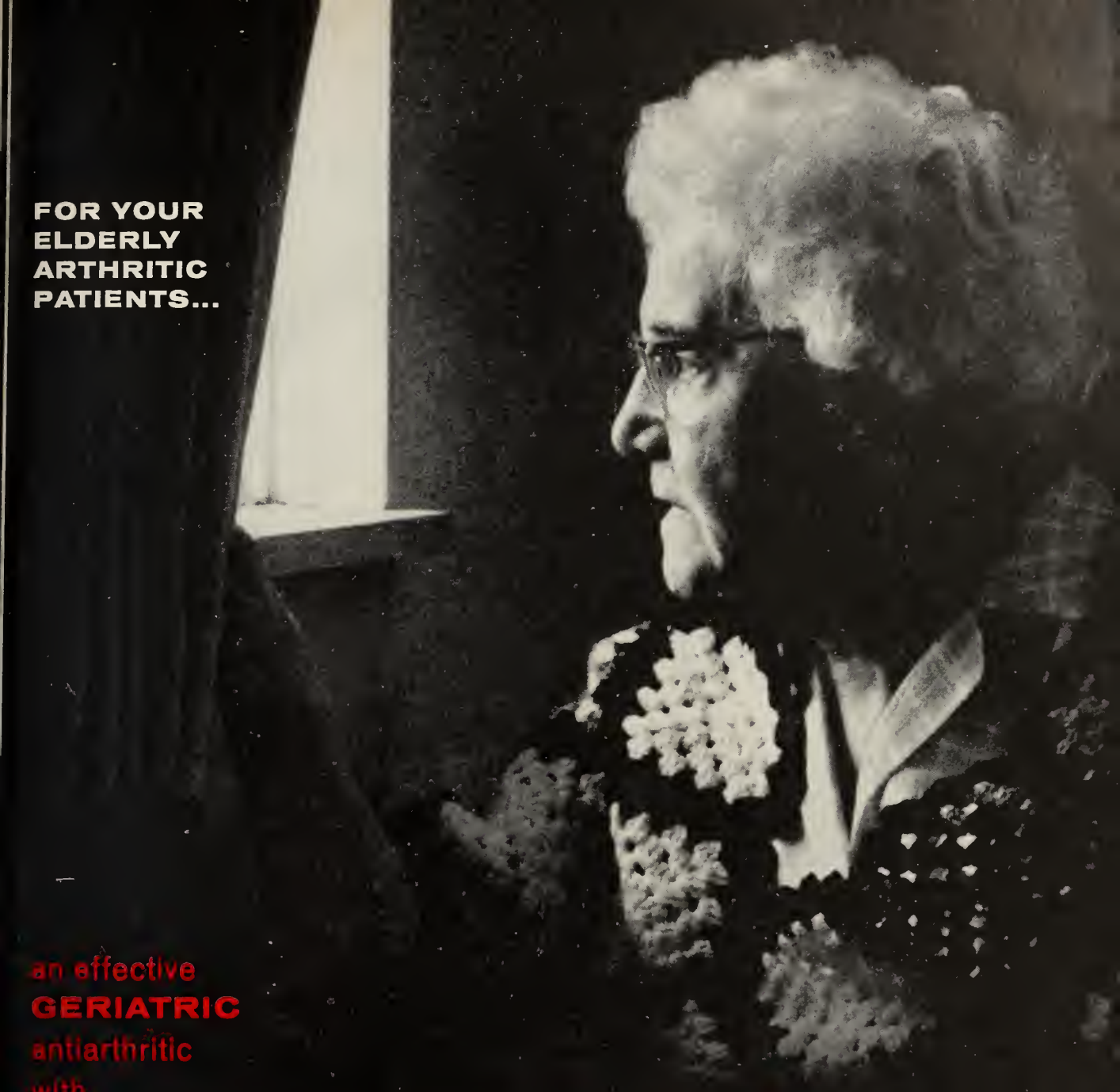
The Michigan Society of Obstetricians and Gynecologists is being led by the following Officers for 1964-65:

John E. Clifford, M.D., Grosse Pointe Farms, President; Robert G. Swanson, M.D., Grosse Pointe Farms, President-Elect; Eli J. Igna, M.D., Grosse Pointe Park, Treasurer; Joseph B. Woolfenden, Grosse Pointe Farms, Secretary. Members of the Council are: Doctors Tommy Evans, Ann Arbor; Robert E. Bogue, Detroit; Charles Aldridge, Jr., Grand Rapids; Ralph Steffe, Flint, and Philip Peven, Detroit.

A highlight at the Michigan Hospital Association meeting was the presentation of the 1964 Key Award for meritorious service to **A. C. Kerlikowske, M.D.**, director of the University of Michigan hospital.

* * *

Two addresess on gout and ankylosing spondylitis will be given by **John W. Sigler, M.D.**, Detroit, at the 49th Annual Scientific Assembly of the Interstate Postgraduate Medical Association at Pittsburgh, Nov. 9-12.



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Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

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Her once unruly appetite is now well tamed with 'Methedrine' (methamphetamine hydrochloride)...an easy way to help control food craving and "hunger pains."

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Complete literature available on request from Professional Services Dept. PML

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

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SOCIO-ECONOMIC

More Doctors in Your County Since 1961? Fewer?

Michigan State Board of Registration in Medicine
REPORT ON 1964 ANNUAL RE-REGISTRATION
(as of March 13, 1964)

COUNTY	1960 POPULATION	M.D.s REGISTERED 1961	1962	1963	1964
Alcona	6,352	0	0	1	0
Alger	9,250	4	7	5	5
Allegan	57,729	26	27	21	32
Alpena	28,556	28	25	21	28
Antrim	10,373	3	4	4	5
Arenac	9,860	0	0	1	1
Baraga	7,151	1	2	1	3
Barry	31,738	18	20	16	16
Bay	107,042	89	91	86	92
Benzie	7,834	2	2	6	5
Berrien	149,865	108	109	109	113
Branch	34,903	24	26	30	28
Calhoun	138,858	129	133	135	138
Cass	36,932	11	11	12	12
Charlevoix	13,421	9	12	11	13
Cheboygan	14,550	7	7	7	7
Chippewa	32,655	19	18	19	16
Clare	11,647	5	5	4	4
Clinton	37,969	16	17	17	16
Crawford	4,971	5	5	5	5
Delta	34,298	21	23	25	26
Dickinson	23,917	21	24	27	30
Eaton	49,684	22	22	19	22
Emmet	15,904	27	29	30	33
Genesee	374,313	309	323	321	325
Gladwin	10,769	5	5	5	5

CONTINUED: STATISTICS FROM STATE BOARD OF REGISTRATION IN MEDICINE

COUNTY	1960 POPULATION	M.D.s REGISTERED 1961	1962	1963	1964
Gogebic	24,370	16	15	13	13
Grand Traverse	33,490	77	72	66	72
Gratiot	37,012	22	23	23	24
Hillsdale	34,742	16	17	17	17
Houghton	35,654	23	24	21	20
Huron	34,006	18	18	16	19
Ingham	211,296	248	254	246	263
Ionia	43,132	25	26	25	27
Iosco	16,505	2	3	5	7
Iron	17,184	13	14	11	10
Isabella	35,348	26	25	25	24
Jackson	131,994	127	125	128	120
Kalamazoo	169,712	199	209	216	221
Kalkaska	4,382	1	2	2	2
Kent	363,187	427	448	433	454
Kewcenaw	2,417	2	0	0	0
Lake	5,338	1	2	2	4
Lapeer	41,926	26	25	24	23
Leelanau	9,321	0	0	1	3
Lenawee	77,789	57	54	55	55
Livingston	38,233	22	21	27	27
Luce	7,827	14	14	19	14
Mackinac	10,853	8	7	7	7
Macomb	405,804	98	102	154	169
Manistee	19,042	14	14	15	14
Marquette	56,154	48	48	45	48
Mason	21,929	18	17	17	17
Mecosta	21,051	10	12	10	10
Menominee	24,685	16	15	12	13
Midland	51,450	42	45	53	50
Missaukee	6,784	3	3	2	2
Monroe	101,120	42	41	43	44
Montcalm	35,795	22	21	23	18
Montmorency	4,424	1	1	1	1
Muskegon	149,943	118	116	124	121
Newaygo	24,160	19	17	18	16
Oakland	690,259	486	541	667	775
Oceana	16,547	8	9	9	8
Ogemaw	9,680	6	6	7	7
Ontonagon	10,584	5	6	7	5
Osceola	13,595	5	5	4	4
Oscoda	3,447	1	4	3	2
Otsego	7,545	8	9	9	7
Ottawa	98,719	61	67	73	67
Presque Isle	13,117	1	2	2	1
Roscommon	7,200	4	5	5	5
Saginaw	190,752	153	162	168	168
Sanilac	32,314	16	16	15	15
Schoolcraft	8,953	4	4	5	5
Shiawassee	53,446	33	34	33	31
St. Clair	107,201	69	69	72	78
St. Joseph	42,332	35	31	31	32
Tuscola	43,305	18	20	22	19
Van Buren	48,395	29	29	32	30
Washtenaw	172,440	591	621	642	692
Wayne	2,666,297	3,155	3,263	3,083	3,126
Wexford	18,466	13	14	20	17
SUB TOTAL		7,431	7,714	7,746	8,024
OUT OF STATE		1,185	2,142	2,092	2,257
TOTALS		8,616	9,856	9,838	10,281
MILITARY (Exempt)			277	399	412

Further Comments on "Pronouncement of Death"

By LESTER P. DODD,
MSMS Legal Counsel

About a year ago I wrote an opinion in response to an inquiry as to whether the law requires a doctor to make a formal "pronouncement of death" in which I said:

> *"The laws of the State of Michigan do not require a specific pronouncement or declaration that a person is dead other than through the signing of a death certificate. You are, of course, familiar with the statutory requirement that the attending physician sign the death certificate. In my opinion this does not mean that the physician must actually be present at the time of the person's death or that he must make any formal pronouncement of death over the body of the deceased. No physician can properly sign a death certificate without satisfying himself that the person referred to is actually dead, but I believe that if a physician who ascertains the fact of death through a registered nurse or other person competent to determine the fact, may properly sign the death certificate without having made any formal pronouncement of death over the body."*

Subsequently, it has been brought to my attention that some doctors have interpreted that opinion as meaning that they have no responsibility to determine that death has actually occurred and that when a nurse or other person calls the doctor by telephone and says "the patient's respiration has apparently ceased", he need only direct the caller to arrange for transfer to the hospital morgue or to release the body to a mortician. Such was not the intent of my former opinion and cannot be recommended as a legally safe general practice.

My original opinion was intended to go no further than to advise that no *formal* "pronouncement" of death was required by law other than the execution of a death certificate and that a doctor might legally execute such a certificate upon ascertaining to his satisfaction that death had, in fact, occurred.

Certainly, there are cases in which a nurse, or even a layman, may be perfectly competent to determine that death has in fact occurred. There are undoubtedly others in which medical judgment is required.

In any case which might conceivably fall into the latter category, it is unquestionably the responsibility of the doctor to determine the fact. In short, physicians may not safely delegate to nurses, nor should nurses be asked to accept, the responsibility of exercising medical judgment in any case in which the ascertainment of the fact of death may involve the exercise of such judgment.

Opinion Available Re Occupational Injuries

The MSMS legal counsel has provided an opinion to the MSMS Occupational Health Committee regarding the legality of non-professional persons treating occupational injuries and other conditions in first aid stations and clinics in Michigan.

In this opinion, Lester P. Dodd, JD, MSMS legal counsel, outlined broadly the status of doctors, registered nurses, licensed practical nurses, Red Cross trained first aid personnel and untrained fellow workers in the operation of such first aid stations and clinics, and pointed out that while the courts have not shown a disposition to construe statutory provisions with such technical nicety as to discourage the maintenance or use of first aid stations, the practice of attempting to furnish complete care (including follow-up care) at the hands of unlicensed personnel is fraught with substantial danger.

A copy of the opinion is available from MSMS for any member who might be interested in this matter.

Bibliography Published On Needs of Aging

A new bibliography, "Income, Resources and Needs of Older People," compiled by Elizabeth Ferguson, librarian of the Institute of Life Insurance, has just been published in booklet form by the National Council on the Aging. The bibliography, contains over 500 references to current and basic material, including many dealing with life and health insurance, most of them published since 1960.

Single copies of the booklet can be obtained at 85¢ each from the National Council on the Aging, 49 West 45th Street, New York, N. Y. 10036. Prices of copies in bulk are available upon request.



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Ampuls: 1 cc. and 2 cc., in boxes of 12 and 100.
(Each cc. of NUMORPHAN® contains 1.5 mg. oxymorphone as the hydrochloride.)
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IN MEMORIAM

ROBERT J. COOPER, M.D.

Robert J. Cooper, MD, 64, of Tucson, Arizona, who had been a Pontiac pediatrician for more than 32 years, died August 19, 1964.

Doctor Cooper was a 1926 graduate of the University of Michigan Medical School and began his practice in Pontiac in 1929.

He held memberships in the American Academy of Pediatrics, the Detroit and University of Michigan pediatric societies and Galens Honorary Medical Society. Doctor Cooper also belonged to Alpha Tau Omega Literary Fraternity and Nu Sigma Nu Medical Fraternity. He was an Associate member of MSMS.

FRANK L. RECTOR, M.D.

Frank L. Rector, MD, 85, of Portland, Oregon, died August 18, 1964.

Former executive secretary of the MSMS Cancer Control Committee and a Life Member of the Michigan State Medical Society, Doctor Rector moved to Portland, Oregon, following his retirement 10 years ago.

Doctor Rector was a graduate of George Washington University medical school in 1907 and served until 1925 as a bacteriologist in New York City. In 1925 he moved to Chicago to serve as editor of *The Nation's Health*, a medical publication, and as executive secretary of the Chicago Medical Society. From 1930 to 1954 Doctor Rector was engaged in cancer educational activities and in 1952 was awarded the Annual Award of the American Cancer Public Health Association. Doctor Rector directed the activities of the MSMS Cancer Control Committee, as its fulltime secretary, for several years prior to his retirement in 1954, when he moved to Portland, Oregon.

He was a Life Member of the American Public Health Association and held membership in numerous other professional organizations.

Glue Still Tacky; Sniffers Not Wacky?

The teenage glue sniffing fad may soon be passé—not because teenagers aren't what they used to be, but because the glue may be changed.

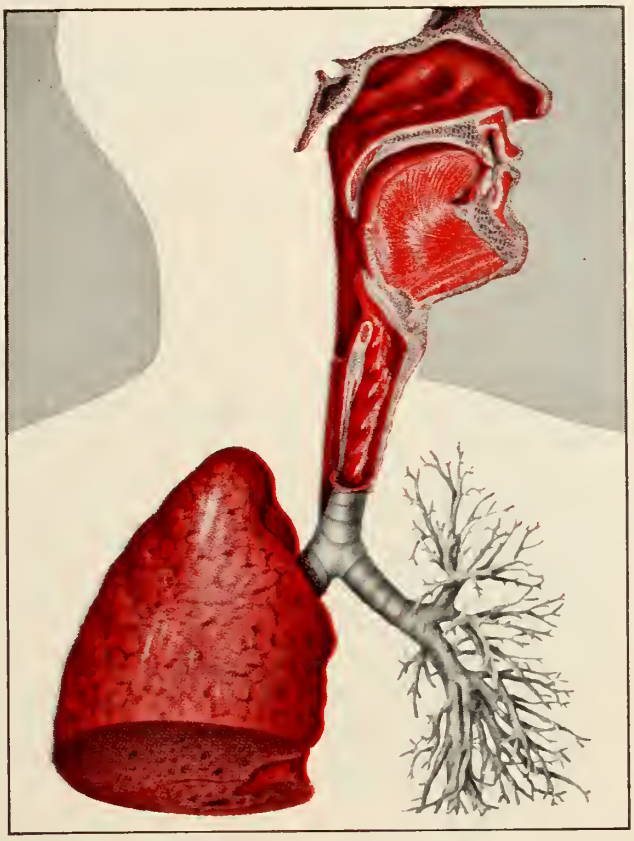
The Hobby Industry Association of America, reports *The AMA News* (June 22), has announced development of a new chemical to replace intoxicating solvents now used in model airplane glues.

Expected to be ready within a year, the new ingredient is hailed as a possible solution to the problem of glue sniffing.

Say you saw it in Michigan Medicine

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Each teaspoonful (5 cc.) contains:

Hycodan®	
Hydrocodone bitartrate ..... 5 mg.	
(Warning: May be habit-forming)	6.5 mg.
Homatropine methylbromide ..... 1.5 mg.	
Pyrilamine maleate	12.5 mg.
Phenylephrine hydrochloride	10 mg.
Ammonium chloride	60 mg.
Sodium citrate	85 mg.

(with methylparaben 0.13% and propylparaben 0.02% as preservatives)

in a highly palatable cherry-flavored vehicle

antitussive • antihistaminic decongestant • expectorant

treats the multiple symptoms of the COUGH/COLD syndrome

• arrests both productive and nonproductive cough • decongests the airways • liquefies secretions responsible for irritation • provides prompt symptomatic relief of allergic symptoms • is well tolerated • rarely causes constipation

DOSAGE: *Average adult dose*—1 teaspoonful after meals and at bedtime with food. *Children 6-12 years,* ½ teaspoonful; *3-6 years,* ¼ teaspoonful; *1-3 years,* 10 drops; *6 months to 1 year,* 5 drops. Administer after meals and at bedtime with food. On oral Rx where state laws permit.

CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

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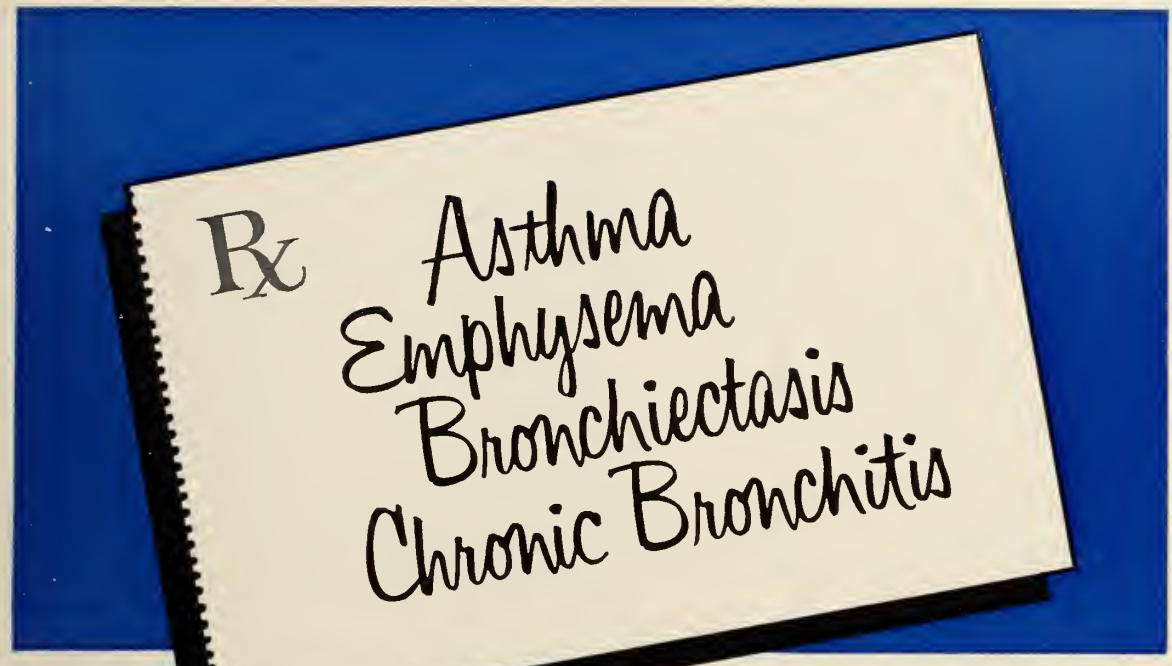
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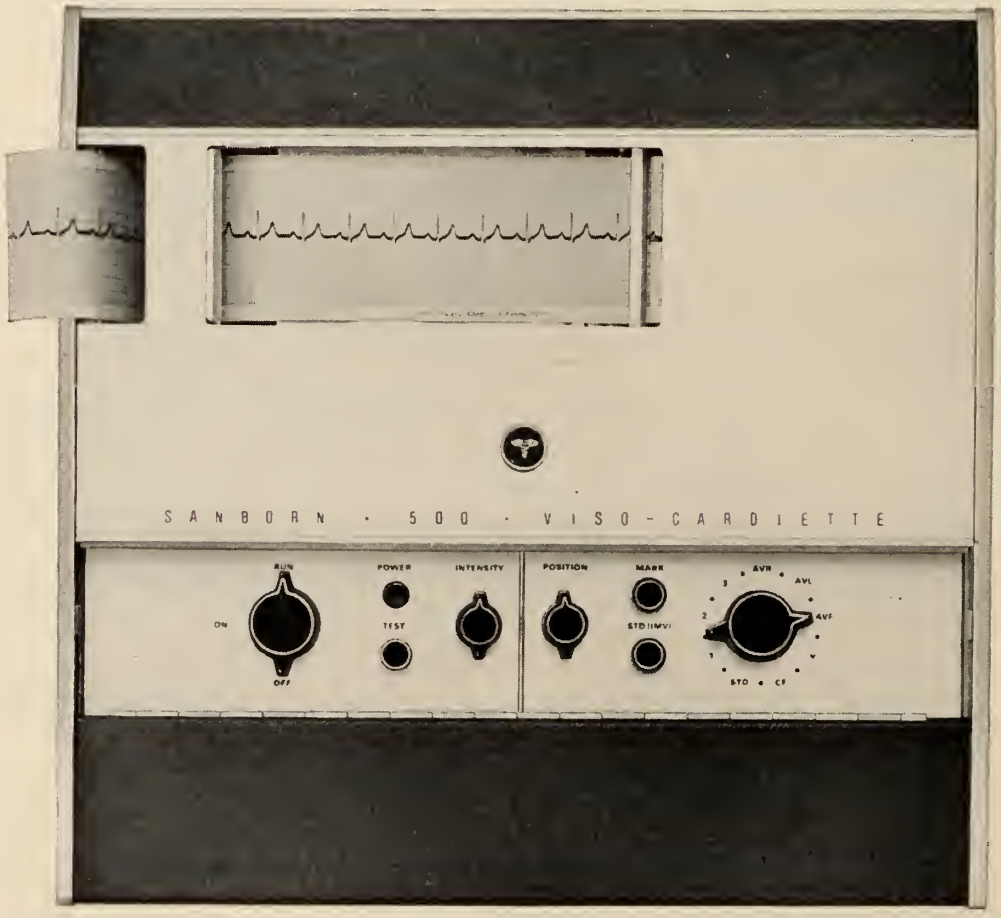


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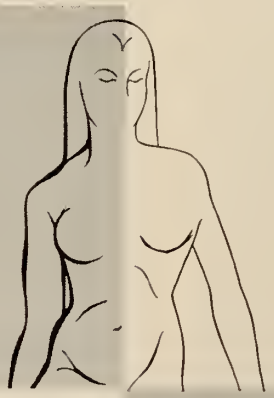
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Books Received

Books received by THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY *are acknowledged in this column. Selections will be made for more extensive review in the interest of readers as space permits.*

REVIEW OF MEDICAL PHYSIOLOGY. By William F. Ganong, M.D., Associate Professor of Physiology, University of California School of Medicine, San Francisco; Consulting Physiologist, Kaiser Foundation Hospital, San Francisco. Published by Lange Medical Publications, Los Altos, California. Price $6.50.

SCHOOL HEALTH EDUCATION STUDY—A SUMMARY REPORT OF A NATIONWIDE STUDY OF HEALTH INSTRUCTION IN THE PUBLIC SCHOOLS. By Elena M. Sliepcevich, Director of the Study (1961-1963). Sponsored by the Samuel Bronfman Foundation of New York City. Single copies of this publication are available upon request from the Director, School Health Education Study, 1201 Sixteenth St. N.W., Washington, D. C.

MODERN TREATMENT, Volume 1, Number 2. Treatment of Pulmonary Diseases, Edited by Carl Muschenheim, M.D.; Treatment of Liver Disease, Edited by Richard B. Capps, M.D. Published by Hoeber, 49 East 33rd Street, New York, New York 10016. Bimonthly publication—$16.00 per year.

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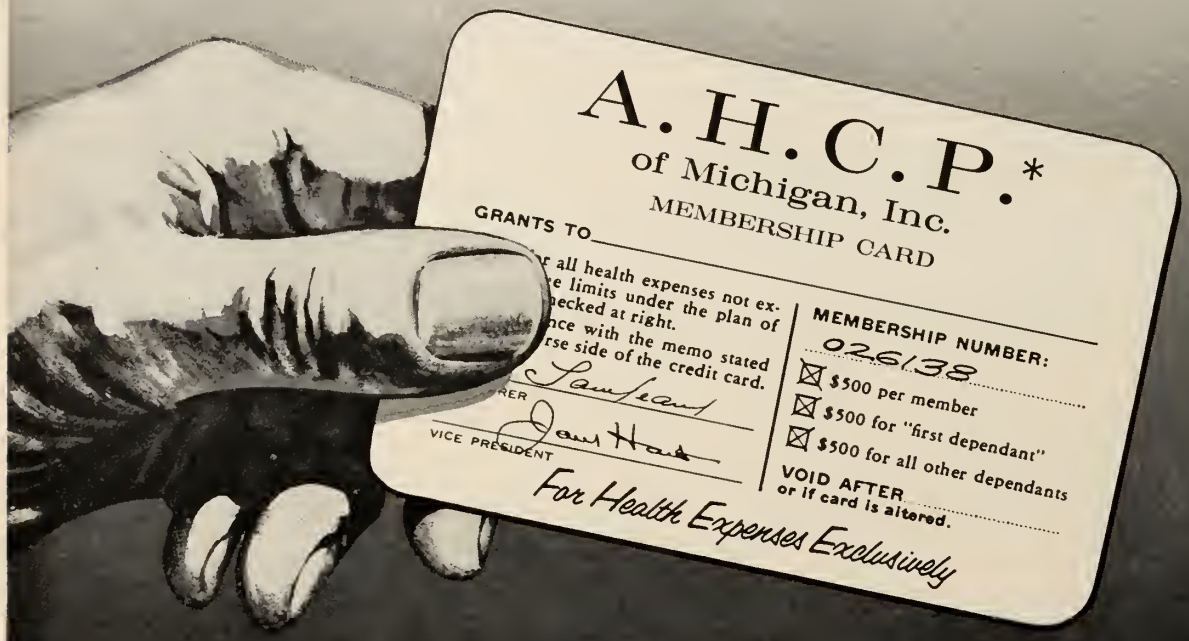
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Bay City (Bay)
Belding (Ionia)
Belleville (Wayne)
Bellevue (Eaton)
Benton Harbor (Berrien)
Berkley (Oakland)
Berrien Springs (Berrien)
Bessemer (Gogebic)
Big Rapids (Mecosta)
Birmingham (Oakland)
Blissfield (Lenawee)
Bloomfield Hills (Oakland)
Boyne City (Charlevoix)
Brighton (Livingston)
Bronson (Branch)
Brookline (Jackson)
Buchanan (Berrien)

Cadillac (Wexford)
Calumet (Houghton)
Capac (St. Clair)
Carleton (Monroe)
Caro (Tuscola)
Carson City (Montcalm)
Cass City (Tuscola)
Cassopolis (Cass)
Cedar Springs (Kent)
Center Line (Macomb)
Charlevoix (Charlevoix)
Charlotte (Eaton)
Cheboygan (Cheboygan)
Chelsea (Washtenaw)
Chesaning (Saginaw)
Clare (Clare)
Clawson (Oakland)

CITY and COUNTY

Clinton (Lenawee)
Clio (Genesee)
Coldwater (Branch)
Colonia (Berrien)
Colon (St. Joseph)
Constantine (St. Joseph)
Coopersville (Kent)
Corunna (Shiawassee)
Croswell (Sanilac)

Davison (Genesee)
Dearborn (Wayne)
Decatur (Van Buren)
Detroit (Wayne)
Dexter (Washtenaw)
Dowagiac (Cass)
Dundee (Monroe)
Durand (Shiawassee)

East Ann Arbor (Washtenaw)
East Detroit (Macomb)
East Grand Rapids (Kent)
East Jordan (Charlevoix)
East Lansing (Ingham)
East Tawas (Iosco)
Eaton Rapids (Eaton)
Ecorse (Wayne)
Escanaba (Delta)
Essexville (Bay)
Evart (Osceola)

Farmington (Oakland)
Fenton (Genesee)
Ferndale (Oakland)
Flat Rock (Wayne)
Flint (Genesee)
Flushing (Genesee)
Fowlerville (Livingston)
Frankenmuth (Saginaw)
Frankfort (Benzie)
Fraser (Macomb)
Fremont (Newaygo)

Galesburg (Kalamazoo)
Garden City (Wayne)
Gaylord (Otsego)
Gladstone (Delta)

CITY and COUNTY

Gladwin (Gladwin)
Grand Haven (Ottawa)
Grand Ledge (Eaton)
Grand Rapids (Kent)
Grandville (Kent)
Grayling (Crawford)
Greenville (Montcalm)
Grosse Pointe (Wayne)
Grosse Pointe Farms (Wayne)
Grosse Pointe Park (Wayne)
Grosse Pointe Shores (Wayne & Macomb)
Grosse Pointe Woods (Wayne & Macomb)

Hamtramck (Wayne)
Hancock (Houghton)
Harbor Beach (Huron)
Harbor Springs (Emmet)
Hart (Oceana)
Hartford (Van Buren)
Hastings (Barry)
Hazel Park (Oakland)
Highland Park (Wayne)
Hillsdale (Hillsdale)
Holland (Ottawa)
Holly (Oakland)
Homer (Calhoun)
Houghton (Houghton)
Howell (Livingston)
Hubbell (Houghton)
Hudson (Lenawee)
Hudsonville (Ottawa)
Huntington Woods (Oakland)

Imlay City (Lapeer)
Inkster (Wayne)
Ionia (Ionia)
Iron Mountain (Dickinson)
Iron River (Iron)
Ironwood (Gogebic)
Ishpeming (Marquette)
Ithaca (Gratiot)

Jackson (Jackson)
Jonesville (Hillsdale)

*See page 1 for Index by counties.

CITY and COUNTY

Kalamazoo (Kalamazoo)
Kalkaska (Kalkaska)
Kingsford (Dickinson)

Lake Linden (Houghton)
Lake Odessa (Ionia)
Lake Orion (Oakland)
Lakeview (Calhoun)
L'Anse (Baraga)
Lansing (Ingham)
Lapeer (Lapeer)
Laurium (Houghton)
Lawton (Van Buren)
Leslie (Ingham)
Lincoln Park (Wayne)
Livonia (Wayne)
Ludington (Mason)

Mancelona (Antrim)
Manchester (Washtenaw)
Manistee (Manistee)
Manistique (Schoolcraft)
Manton (Wexford)
Marcellus (Cass)
Marine City (St. Clair)
Marlette (Sanilac)
Marquette (Marquette)
Marshall (Calhoun)
Marysville (St. Clair)
Mason (Ingham)
Melvindale (Wayne)
Menominee (Menominee)
Michigan Center (Jackson)
Middleville (Barry)
Midland (Midland)
Milan (Monroe & Washtenaw)
Milford (Oakland)
Millington (Tuscola)
Monroe (Monroe)
Montague (Muskegon)
Morenci (Lenawee)
Mount Clemens (Macomb)
Mount Morris (Genesee)
Mount Pleasant (Isabella)
Munising (Alger)
Muskegon (Muskegon)
Muskegon Heights (Muskegon)

Nashville (Barry)
Negaunee (Marquette)
Newaygo (Newaygo)
New Baltimore (Macomb & St. Clair)
Newberry (Luce)
New Buffalo (Berrien)

CITY and COUNTY

Niles (Berrien)
North Muskegon (Muskegon)
Northville (Wayne & Oakland)
Norway (Dickinson)

Oak Park (Oakland)
Onaway (Presque Isle)
Ontonagon (Ontonagon)
Otsego (Allegan)
Ovid (Clinton)
Owosso (Shiawassee)
Oxford (Oakland)

Painesdale (Houghton)
Parchment (Kalamazoo)
Paw Paw (Van Buren)
Pentwater (Oceana)
Perry (Shiawassee)
Petersburg (Monroe)
Petoskey (Emmett)
Pigeon (Huron)
Pinconning (Bay)
Plainwell (Allegan)
Pleasant Ridge (Oakland)
Plymouth (Wayne)
Pontiac (Oakland)
Port Huron (St. Clair)
Portland (Ionia)

Quincy (Branch)

Reading (Hillsdale)
Reed City (Osceola)
Richmond (Macomb)
River Rouge (Wayne)
Riverview (Wayne)
Rochester (Oakland)
Rockford (Kent)
Rockwood (Wayne)
Rogers City (Presque Isle)
Romeo (Macomb)
Roseville (Macomb)
Royal Oak (Oakland)

Saginaw (Saginaw)
Saint Clair (St. Clair)
Saint Clair Shores (Macomb)
Saint Ignace (Mackinac)
Saint Johns (Clinton)
Saint Joseph (Berrien)
Saint Louis (Gratiot)
Saline (Washtenaw)
Sandusky (Sanilac)

CITY and COUNTY

Saugatuck (Allegan)
Sault Sainte Marie (Chippewa)
Schoolcraft (Kalamazoo)
Scottville (Mason)
Sebewaing (Huron)
Shelby (Oceana)
Southfield (Wayne)
South Haven (Van Buren)
South Lyon (Oakland)
Sparta (Kent)
Spring Lake (Ottawa)
Stambaugh (Iron)
Standish (Arenac)
Stanton (Montcalm)
Stockbridge (Ingham)
Sturgis (St. Joseph)
Sylvan Lake (Oakland)

Tawas City (Iosco)
Tecumseh (Lenawee)
Three Rivers (St. Joseph)
Traverse City (Grand Traverse)
Trenton (Wayne)

Union City (Branch & Calhoun)
Utica (Macomb)

Vandercook Lake (Jackson)
Van Dyke (Macomb)
Vassar (Tuscola)
Vicksburg (Kalamazoo)

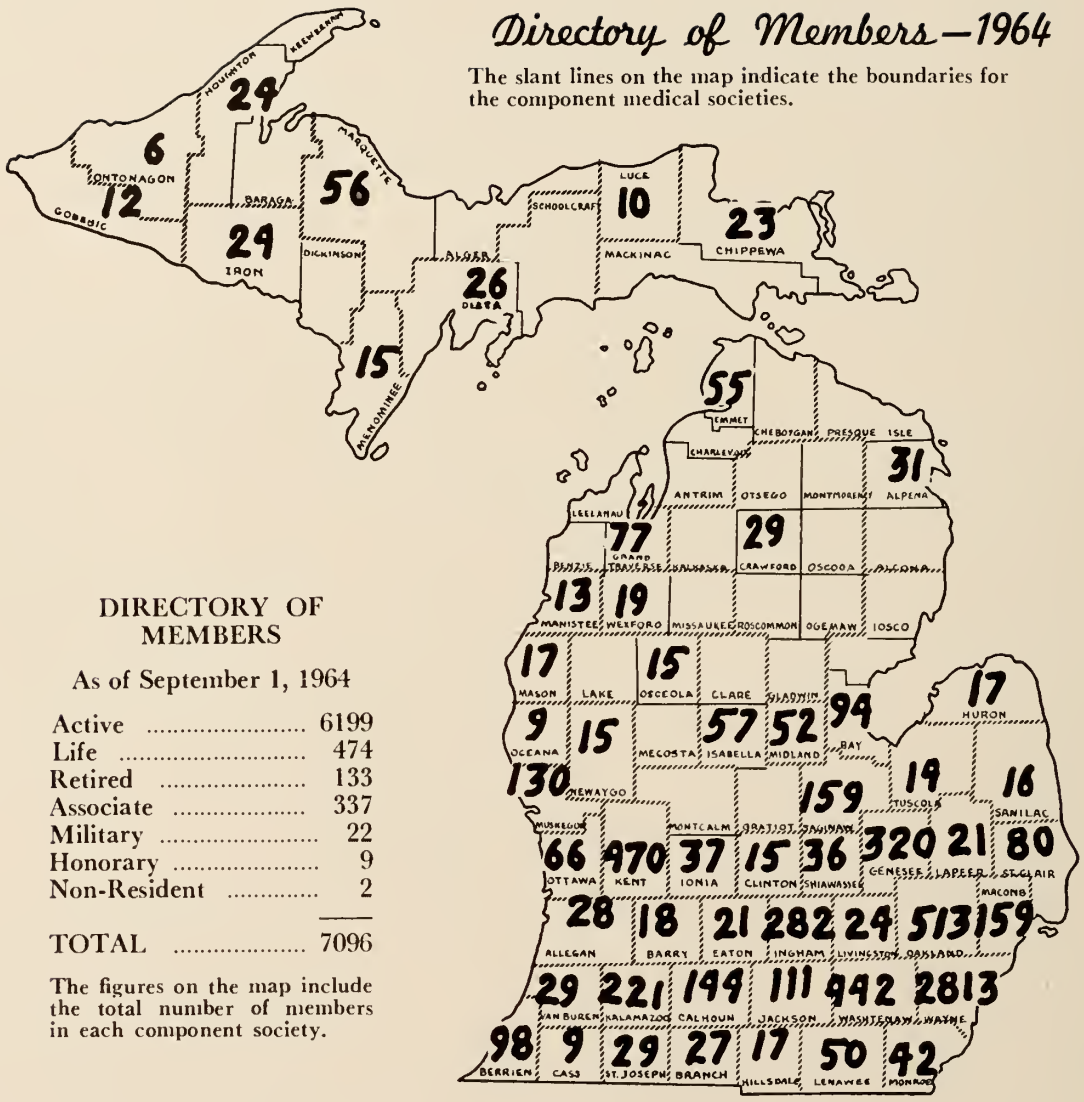
Wakefield (Gogebic)
Walled Lake (Oakland)
Warren (Macomb)
Watervliet (Berrien)
Wayland (Allegan)
Wayne (Wayne)
West Branch (Ogemaw)
Whitehall (Muskegon)
White Pigeon (St. Joseph)
Wyandotte (Wayne)
Wyoming (Kent)

Yale (St. Clair)
Ypsilanti (Washtenaw)

Zeeland (Ottawa)

Directory of Members—1964

The slant lines on the map indicate the boundaries for the component medical societies.



DIRECTORY OF MEMBERS

As of September 1, 1964

Active	6199
Life	474
Retired	133
Associate	337
Military	22
Honorary	9
Non-Resident	2
TOTAL	7096

The figures on the map include the total number of members in each component society.

Michigan State Medical Society

Directory of Members, 1964

Listed by Component Medical Societies

(Special Memberships are indicated as follows: "L" for Life Members; "M" for Military Members; "N" for Non-Resident Members; "R" for Retired Members; "A" for Associate Members; all others are Active Members)
(Numbers in parentheses indicate County Society Code Numbers used in the Alphabetical Roster)

ALLEGAN COUNTY MEDICAL SOCIETY (10)

Brachman, A. Peter, Jr.....222 Trowbridge St., Allegan
Brown, Lewis F.....133 E. Allegan St., Otsego
Chase, Walter E.....137½ N. Main St., Plainwell
Clark, James I. (A).....Box B, Fennville
Doorn, Henry A.....3032 Burlingame Ave., Wyoming City
Everett, D. W. .....Plainwell Sanitarium, Plainwell
Goddard, G. B.....218 E. Orleans, Otsego
Goude, Albert G. (A).....Ahoada Co. Hospital, Ahoada, East Nigeria, West Africa
Hays, James D.....Douglas
Johnson, Elwin B.....144 Brady St., Allegan
Johnson, Harrison H. (L).....Wayland
Keller, Van O.....Otsego
Mahan, James E.....402 Trowbridge St., Allegan
Medill, Wilbur C.....139 N. Main St., Plainwell
Miller, Kenneth C.....Saugatuck
Mitchell, Abbott B.....County Health Dept., Allegan
Pone, Janis.....Martin
Proos, Richard A.....304 Dix St., Otsego
Ramseyer, Gladwin E.....125 E. Bridge, Plainwell
Schneiter, Harry E.....425 Cutler St., Allegan
Schock, William H.....315 Maple St., Saugatuck
Smith, Roger J.....723 S. Westnedge St., Kalamazoo
Topp, E. Robert.....2402 West B Ave., Plainwell
Topp, Elwin W.....502 N. Main St., Plainwell
Van Der Kolk, Bert.....Hopkins
Vander Voord, Gerald.....312 E. Plum St., Wayland
Vaughan, Willard R. (L).....Plainwell
Wiseman, Bertha A.....Box 177, Allegan

ALPENA-ALCONA-PRESQUE ISLE COUNTY MEDICAL SOCIETY (14)

Aliferis, Peter.....Alpena General Hosp., Alpena
Arscott, Edward F.....Rogers City
Brown, Donald C.....312 E. Chisholm St., Alpena
Bunting, John W.....110 N. 1st Ave., Alpena
Burkholder, H. J. (L).....122 N. Second Ave., Alpena
Cohn, Stuart L.....1253 W Washington, Alpena
Constantine, Aeneas.....Harrisville
Finch, Donald E.....Onaway
Foley, Richard.....Rogers City
Fox, William L.....601 W. Chisholm St., Alpena
Grause, Thomas J.....312 E. Chisholm St., Alpena
Hier, Edward A.....125 N. Second Ave., Alpena
Jackson, Wm. F.....Rogers City
Kessler, Harold.....312 E. Chisholm St., Alpena
Kutsche, W. F.....208 Lake St., Oscoda
Leopard, J. M.....312 E. Chisholm, Alpena
Lipski, John G. (A).....Traverse State Hosp., Traverse City
Nesbitt, Wm. E.....123 N. 2nd Ave., Alpena
Newman, Roy E.....Alpena General Hosp., Alpena
O'Dell, F. C., Jr.....110 W. Chisholm St., Alpena
Parmenter, Elbert S.....Box 192, Alpena
Ramsey, J. Allen.....312 E. Chisholm, Alpena
Ries, Robt. C.....Rogers City
Riker, John L.....303 N. Second Ave., Alpena
Rowell, Wilfred J.....Alpena Gen. Hosp., Alpena
Spens, James E.....123 N. Second Ave., Alpena
Stump, G. D.....123 N. Second, Alpena
Wagoner, Darwin E.....5007 N. Cedar Lake Rd., Oscoda
Watkins, T. M.....312 E. Chisholm St., Alpena
Wienczewski, T. W.....811 Chisholm St., Alpena
Wilson, Chas. S. (L).....730 State Ave., Alpena

BARRY COUNTY MEDICAL SOCIETY (18)

Birk, Wilbur R.....110 W. Center, Hastings
Brown, Jack A.....303 Broadway, Middleville
Castleman, Douglas H.....110 W. Center, Hastings
Finnie, Gordon M.....535 E. Francis, Hastings
Finnie, R. G.....535 E. Francis, Hastings
Gwinn, Alexander B.....118 E. Walnut, Hastings
Heaslip, Jos. D. (R).....627 W. Madison St., Hastings
Huebner, R. J.....110 W. Center, Hastings
Lofdahl, Stewart (R).....Rt. 1, Box 172, St. Charles, Ill.
Logan, Wesley G.....City Bank Bldg., Hastings
Lundeen, John G.....595 Jordon Lake, Lake Odessa
Morrill, Charles E.....400 W. State St., Hastings
Myers, Thos. W.....307 N Main St., Nashville
Noah, Melvin L. (A).....St. Marys Hosp., Grand Rapids
Phelps, Everett L.....535 E. Francis St., Hastings
Pryor, Robt B.....400 W. State St., Hastings
Tromp, Jack L.....Rt. 3, Lake Odessa
Wedel, Herbert S.....110 W. Center, Hastings

BAY-ARENAC-IOSCO COUNTY MEDICAL SOCIETY (22)

Alcorn, Kent A.....1420 Center Ave., Bay City
Alcorn, Marshall W.....1420 Center Ave., Bay City
Allen, Arthur D.....101 W. John St., Bay City
Antle, Robert C.....101 W. John St., Bay City
Asbury, Richard B.....2110 16th St., Bay City
Asline, John N.....207 N. Walnut St., Bay City
Austin, Justus J. (R).....Tawas City
Bowman, David A.....101 W. John St., Bay City
Bozdech, Jiri Josef.....900 N. Jackson, Bay City
Brenner, Frederick.....900 N. Jackson, Bay City
Brinkman, Harvey H.....116 W. State St., East Tawas
Brown, Geo. M.....207 N. Walnut St., Bay City
Campbell, Donald A.....700 Borton, Essexville
Campbell, John S.....1833 McKinley Ave., Bay City
Chapin, Fredk. J.....2121 Center Ave., Bay City
Cook, Hugh K.....101 W. John St., Bay City
Cook, Raymond R.....1115 Fifth St., Bay City
Cooper, James C.....705 Oak St., Essexville
Cosens, Stanley A.....101 W. John St., Bay City
Crissey, Robt. R.....101 W. John St., Bay City
Criswell, Robt. H.....721 Washington Ave., Bay City
Csonka, Nicholas.....1308 Columbus Ave., Bay City
Dardas, Michael J.....1413 Center Ave., Bay City
Dolbee, Malcolm K.....Box 518, Standish
Ellison, Alfred, Jr.....101 John St., Bay City
Ferguson, Robert.....101 W. John St., Bay City
Follis, Wm. M.....101 W. John, Bay City
Gamble, Wm. G., Jr.....2010 5th Ave., Bay City
Gehman, J. R.....Standish
Geneczko, John T.....1102 Columbus Ave., Bay City
Grigg, John W.....2110 Sixteenth St., Bay City
Hafford, Robert C.....101 W. John St., Bay City
Hagelshaw, Gayland L.....101 W. John St., Bay City
Hess, Chas. L. (R).....(Address Unknown)
Heuser, Harold H.....916 Washington Ave., Bay City
Hickner, Lawrence P.....101 W. John St., Bay City
Horowitz, Saml. F.....1415 Center Ave., Bay City
Howland, Walter L.....P.O. Box 633, Pinconning
Huckins, Rodgers S.....1802 Broadway, Bay City
Jacoby, Abraham H.....2202 Ninth St., Bay City
Jacques, J. E.....Tawas City
Jaffe, Martin D.....2110 16th St., Bay City
Jens, Otto F.....1506 Prairie St., Essexville
Johnson, Orlen J.....207 N. Walnut St., Bay City
Jones, M. Culver.....900 N. Jackson, Bay City
Jones, Tyre K., III.....1912 Brentwood, Essexville
Kelly, Larry Stanley.....Tawas City
Kessler, Mana.....311 Center Ave., Bay City
Kessler, Sabina.....311 Center Ave., Bay City
Knobloch, Howard T.....1102 Columbus, Bay City
Kovacsi, Laszlo.....1903 33rd St., Bay City
Kruger, Harold F.....300 N. Henry, Bay City
Kulinski, Eugene J.....2110 16th St., Bay City
Langin, John L.....100 15th St., Bay City
Loree, Joseph.....1407 Center Ave., Bay City
MacRae, Leonard D.....813 Sherman St., Bay City
Mayne, John C.....101 W. John St., Bay City
McGee, Harry B.....101 W. John, Bay City
McGee, Peter L.....2110 16th St., Bay City
McSherry, Leo B., Jr.....1102 Columbus Ave., Bay City
Medvezky, Michael J.....1106 S. Madison Ave., Bay City
Miller, Edwin C.....101 W. John St., Bay City
Moeller, Arlyn.....700 Borton Ave., Essexville
Moore, Allen B.....700 Borton Ave., Essexville
Moore, Neal R.....704 N. Jackson, Bay City
Mosier, Dwight J.....101 W John St., Bay City
Nixon, Robert S.....101 W. John St., Bay City
Parks, Floyd R., Jr.....101 W. John St., Bay City
Payea, Norman P.....217 Newman St., East Tawas
Pearson, Stanley M.....101 W. John St., Bay City
Pelczar, Walter E.....321 N. Johnson St., Bay City
Prophater, Robt. C.....202 Boehringer Ct., Bay City
Rodda, E. H.....101 W. John St., Bay City
Rogers, Charles S.....101 W. John St., Bay City
Rowe, Paul W.....Mercy Hospital, Bay City
Schmelzer, Wm. J.....602 Mercer St., P.O. 746, Pinconning
Shafer, Harold C.....101 W. John St., Bay City
Shields, Hubert L.....101 W. John St., Bay City
Staley, Hugh O.....Omer
Standiford, David.....2110 16th St., Bay City
Stroia, Livius N.....101 W. John St., Bay City
Sutton, R. L., Jr.....116 W. State St., East Tawas
Sweet, Irwin.....Gladwin
Taheri, Zia E.....1411 Center Ave., Bay City
Tarter, Clyde S. (R).....Star Route, Alpena
Tompkins, Dana A.....Pinconning
Treadway, Gaylord.....900 N. Jackson, Bay City
Vail, Harry F.....1107 Columbus Ave., Bay City
Way, John H.....83 Cedar Dr., Bay City
Wilson, Thos. G. (R).....Rt. 2, Box 112H, Tawas City
Woodburne, Harris L.....1420 Center St., Bay City
Wright, Thomas B.....101 W. John St., Bay City
Zaremba, Aloysius J. (L).....108 S. Madison Ave., Bay City
Ziliak, Alois L., Jr.....3393 Kiesel Rd., Bay City

BERRIEN COUNTY MEDICAL SOCIETY (26)

Asselin, Dean R.....2817 S. State St., St. Joseph
Atkinson, Robert L.....1626 Langley Ave., St. Joseph
Bailey, John H.....2150 Samuel Ave., Benton Harbor
Beal, Gerald N.....Sheperd Benning Bldg., St. Joseph
Benner, Wm. H.....700 Empire Rd., Benton Harbor
Bieri, Dixon L.....208 Brown School Rd., St. Joseph
Bliesmer, August F.....505 Pleasant St., St. Joseph
Brink, John W.....811 Myrtle St., St. Joseph
Bronfenbrenner, Jack.....687 E. Empire Ave., Benton Harbor
Bruni, John R.....1 South Fifth St., Niles
Camp, Donald C.....8 N. St. Joseph Ave., Niles
Carter, John H.....687 E. Empire Ave., Benton Harbor
Cawthorne, Harold J. (R).....Rt. 4, Box 201, Coloma
Chickering, Wm. A.....205 E. Delaware St., Benton Harbor
Cilella, S. G.....Pawating Hospital, Niles
Conway, Jos.....Watervliet
Conybeare, Robt. C.....756 Pipestone, Benton Harbor
Cooke, Weldon.....Berrien County Hosp., Berrien Center
Cooper, Wm. L.....Rt. 1, Paw Paw Island, Coloma
Crowell, Richard C.....645 Riverview Dr., Benton Harbor
Dailey, Walter S.....122 Grant St., Niles
Dalgleish, Archie J.....460 N Main St., Watervliet
Elghammer, Richard M.....1106 Highland Ave., St. Joseph
Elliott, J. Colin.....802 E. Front St., Buchanan
Emery, Clayton S.....1020 Niles Ave., St. Joseph
Emery, Wm. K.....1020 Niles Ave., St. Joseph
Faber, Michael.....756 Pipestone St., Benton Harbor
Fattic, Grover R., Jr.....Box 427, Niles
Feeley, Marshall J.....2516 Niles Ave., St. Joseph
Friedman, Morris E.....Barton St., New Buffalo
Galles, James O.....275 Paw Paw Ave., Coloma
Garrett, Evan L.....P.O. Box 427, Niles
Gillette, Clarence (L).....R.F.D. 4, M 60 W., Niles
Gould, Samuel H.....127 Napier Ave., Benton Harbor
Grayson, Chas. J.....4 Maple St., Three Oaks
Green, Barbara G.....2600 Morton St., St. Joseph
Green, Robt. L.....2600 Morton St., St. Joseph
Hassan, D. Kent.....802 E. Front St., Buchanan
Haupt, Edward C.....687 E. Empire, Benton Harbor
Hayes, Thos. P.....2821 State St., St. Joseph
Henderson, Fred C.....703 E. Main, Niles
Hershey, Noel J.....P.O. Box 222, Niles
Hills, David W.....2821 State St., St. Joseph
Holt, Robt. E.....9 S. St. Joseph Ave., Niles
Howard, Frank W.....756 Pipestone, Benton Harbor
Hudnutt, Dean.....811 Myrtle St., St. Joseph
Huff, Harold D.....126 Main St., Niles
Irgens, Edwin R.....11 Peoples St. Bk. Bldg., St. Joseph
Johnston, Wm. H.....2522 Niles Ave., St. Joseph
Kelsall, Harvey I.....1600 Niles Ave., St. Joseph
Kenfield, W. J.....505 Pleasant St., St. Joseph
Kennedy, F. Alan.....315 Fidelity Bldg., Benton Harbor

King, Frank A., Jr.....169 Michigan St., Benton Harbor
Klos, Henry J.....2700 Highland Ct., St. Joseph
Krug, Edward G.....12 N. Fourth St., Niles
Landgraf, Robt. L.....P.O. Box 222, Niles
Learned, David W.....870 Union, Benton Harbor
Leva, John B.....1122 Salem Ave., Benton Harbor
Lindenfeld, Fredk. H.....8 N. St. Joseph Ave., Niles
Lininger, Richard E.....2712 Highland Ct., St. Joseph
Manning, John T.....1150 Miami Rd., Benton Harbor
May, A. J.....2821 State St., St. Joseph
McLelland, J. T...Mercy Hosp. X-Ray Dept., Benton Harbor
McNabb, Arthur A. (L).....469 Main St., Watervliet
Mesirow, Stanley M.....687 E. Empire Ave, Benton Harbor
Miller, Edward A. (R).....720 Seneca St., Seattle, Wash.
Moore, T. Scott.....P.O. Box 416, Niles
Namtze, Chan.....8 N. St. Joseph Ave., Niles
O'Toole, John.....133 E. Napier, Benton Harbor
Ozeran, Chas. J.....127 E. Napier, Benton Harbor
Padelford, Wm. J.....South Lyon
Payne, Charles E.....925 Pipestone St., Benton Harbor
Peshka, David K.....P.O. Box 427, Niles
Polansky, Sanford.....84 W. Main St., Benton Harbor
Porter, Chas. B.....1589 Colfax Ave., Benton Harbor
Pritchard, Harold M.....502 Broadway, Niles
Qadir, Syed A.....113 N. Portage, Buchanan
Quinn, Leo F.....1111 Oak St., Niles
Rague, Paul O.....960 Agard, Benton Harbor
Rambo, Joseph J.....505 Lake St., Bridgeman
Ray, Dean K.....2522 Niles, St. Joseph
Reagan, Robt. E.....232 Windsor, Benton Harbor
Richmond, Dean M.....314 State St., St. Joseph
Ruth, J. Griswold.....507 Britain Ave., Benton Harbor
Skinner, James W.....460 Ridgeway St., St. Joseph
Smith, W. B.....133 E. Napier, Benton Harbor
Sowers, Bouton F.....756 Pipestone St., Benton Harbor
Strayer, John W.....P.O. Box 222, Niles
Stulik, Chas. K.....Town Line Rd., P.O. Box 98, Union Pier
Turner, John J.....2817 S. State St., St. Joseph
Urist, Maurice D.....454 Pipestone St., Benton Harbor
Valantiejus, John A.....Rt. 2, Cedar Lane Farm, New Buffalo
Vastine, Russell J., Jr.....430 W. Chicago, Buchanan
Watkins, Richard W. (L).....131 E. Napier, Benton Harbor
Westervelt, H. O. (L).....539 Pearl St., Benton Harbor
Willson, Dean.....756 Pipestone, Benton Harbor
Woodford, Hackley E.....599 E. Main, Benton Harbor
Zick, Luther H.....2522 Niles Ave., St. Joseph

BRANCH COUNTY MEDICAL SOCIETY (30)

Aldrich, Napier S.....162 Marshall St., Coldwater
Bacon, Charles R.....300 E. Chicago St., Coldwater
Bailey, James E., Jr.....300 E. Chicago St., Coldwater
Beatty, James B.....300 E. Chicago St., Coldwater
Beck, Perry C. (L).....Box 25, Bronson
Bien, Walter W. J. (L).....65 N. Monroe St., Coldwater
Burke, James M.....40 Balfour Dr., Coldwater
Coates, Carl A.....135 Stringtown, Rt. 1, Quincy
Culver, Dean T.....173 E. Chicago St., Coldwater
Fraser, Robt. J.....22 W. Pearl St., Coldwater
Geib, Ormond D.....State Home Trng. School, Coldwater
Gomley, Henry C.....108 E. Chicago St., Bronson
Harris, Donald M.....490 Griswold, Northville
Heffelfinger, John C.....292 E. Chicago St., Coldwater
Hoeksema, Ronald H.....292 E. Chicago St., Coldwater
Leitch, Robt. M.....401 Ann St., Union City
Meier, Harold J.....87 W. Pearl St., Coldwater
Mooi, Henry R.....292 E. Chicago St., Coldwater
Moss, Harvey L.....47 Carlyle, Coldwater
Nettleman, Wm. E.....87 W. Pearl St., Coldwater
Olmsted, Kenneth L.....675 Monroe, Coldwater
Rennell, Edwin J.....Coldwater State Home, Coldwater
Rick, John J.....61 E. Chicago St., Coldwater
Thomas, James A.....390 E. Chicago St., Coldwater
Walton, Nathaniel J.....Box 148, Coldwater
Weidner, Harold R.....50 Division St., Coldwater
Wise, Robert.....State H.M. & Trng. School, Coldwater

CALHOUN COUNTY MEDICAL SOCIETY (34)

Albright, Arnold A.....401 Security Tower, Battle Creek
Allen, R. H.....191 College, Battle Creek
Amos, Norman H.....710 North Ave., Battle Creek
Amos, Norman O.....710 North Ave., Battle Creek
Anderson, Harold E.....65 W. Michigan Ave., Battle Creek
Arnold, George K. (A).....VA Hospital, Ft. Custer
Azuela, Victor.....185 N. Washington, Battle Creek
Bakken, Richard L.....200 College St., Battle Creek
Barden, Stuart P.....Leila Hosp., Battle Creek
Baribeau, Roy H. (L)....65 W. Michigan Ave., Battle Creek
Becker, Harry F. (L).....Box 547, Battle Creek
Berghorst, John (A).....VA Hospital, Battle Creek
Bodine, Harold R.....231 North Ave., Battle Creek
Bonifer, Philip P., Jr...401 Security Bk. Bldg., Battle Creek
Bonifer, Philip P.....231 North Ave. Battle Creek
Boswell, David E.....105 N. Jefferson Ave., Marshall
Brainard, C. W. (L).....148 Wahwah Tay See Way, Battle Creek
Braverman, A. H. (A).....888 Intracoastal Dr., Ft. Lauderdale, Fla.
Brown, Robt. W.....203 Capital N.E., Battle Creek
Buell, Martin F. (A).....VA Hospital, Ft. Custer
Campbell, Alice F.....103 E. Mulberry St., Albion
Campbell, Jack S.....1018 North Ave., Battle Creek
Campbell, Richard J.....140 Capital Ave. N.E., Battle Creek
Capron, M. J., Jr.....806 Security Bk. Bldg., Battle Creek
Caviness, L. Harold.....185 N. Washington, Battle Creek
Chandler, Edward M.....411 Mich. Nat. Bk. Bldg., Battle Creek
Chynoweth, Wm. R. (L).....207 Post Bldg., Battle Creek
Coakes, Jack E.....112 W. Mansion, Marshall
Colquhoun, Graham F.....188 College St., Battle Creek
Cram, Ralph A.....500 S. Ionia St., Albion
Curry, Robt. K.....Homer
Daly, Harold L., Jr.....500 S. Ionia St., Albion
Daly, Mary.....500 S. Ionia St., Albion
Daly, Miriam S.....500 S. Ionia St., Albion
D'Aversa, Generoso.....5535 Columbia Pike, Arlington
Diamante, Paul J.....710 North Ave., Battle Creek
Dickson, Albert R. (L).....250 Champion St., Battle Creek
Dodge, Warren M., Jr.....1207 Wolverine Tower, Battle Creek
Fairbanks, Stephen.....306 S. Superior, Albion
Ferazzi, Patrick S.....1018 North Ave., Battle Creek
Finch, Duward L.....719 Capital Ave. S.W., Battle Creek
Fisher, Robt. E.....1501 W. Michigan Ave., Battle Creek
Fraser, Robt. H. (L).....25 W. Michigan Ave., Battle Creek
Funk, L. D.....133 W. Burr Oak, Athens
Gething, Jos. W. (L)....538 W. Michigan Ave., Battle Creek
Giddings, A. M. (L).....103 Dieker Pl., St. Marys, Ohio
Gilfillan, Margery J. (L).....125 56th Ave. S., St. Petersburg, Fla.
Girardot, John G.....25 W. Michigan, Battle Creek
Graubner, Franklin L.....Bogar Theater Bldg., Marshall
Gray, J. Alan.....309 Mich. Natl. Bk. Bldg., Battle Creek
Griffith, Jack C.....616 Mich. Natl. Bk. Bldg., Battle Creek
Hamady, Alfred.....1018 North Ave., Battle Creek
Hansen, Edwin L.....216 North Ave., Battle Creek
Hansen, Harvey C.....65 W. Michigan Ave., Battle Creek
Henderson, Philip M.....109 W. Erie, Albion
Henriksen, J. D.....236 Beckwith Dr., Battle Creek
Herman, Louis (A).....VA Hospital, Coral Gables, Fla.
Hibbs, Donald K.....117 Sunnyside Dr., Battle Creek
Holtom, Benj. G.....815 Security Tower, Battle Creek
Hooker, Lyle T. (A).....VA Hospital, Battle Creek
Hubly, James W.....1509 Security Natl. Bk., Battle Creek
Humphrey, Archie E.....864 E. Michigan St., Marshall
Humphrey, Arthur A.....175 College St., Battle Creek

Humphrey, Herbert E.....122 N. Madison St., Marshall
Huntington, John.....710 North Ave., Battle Creek
Jeffrey, James R. (L).....179 N. Washington Ave., Battle Creek
Jones, Aubrey H. (A).....VA Hospital, Ft. Custer
Jones, Ernest F. (A)....Kalamazoo State Hosp., Kalamazoo
Jones, Tyre K.....118 W. Green, Marshall
Kavanagh, Thomas W.....710 North Ave., Battle Creek
Keeler, Kenneth B. (R).....417 Elizabeth St., Albion
Kelleher, Geo. T.....235 North Ave., Battle Creek
Kimball, Arthur S., Jr.....1150 E. Michigan, Battle Creek
Kinde, Matthew R.....250 Champion, Battle Creek
Kingsley, Paul C.....191 College, Battle Creek
Klopp, Edward J.....173 College St., Battle Creek
Knode, Robert Edwin.....407 Mich. Natl. Bk. Bldg., Battle Creek
La France, N. F. (A).....VA Hospital, Augusta, Ga.
Lakke, Gordon W.....163 North Ave., Battle Creek
Lam, Francis L.....408 Capital Ave. S.W., Battle Creek
Lancaster, Vance B.....710 North Ave., Battle Creek
Levy, Elizabeth H. (A).....145 Fuller Rd., Box 42, Battle Creek
Levy, Jos., Jr.....231 North Ave., Battle Creek
Lewis, Welcome B. (L)..196 Irving Park Dr., Battle Creek
Long, Walter B.....Homer
Lowe, Kenneth H.....231 North Ave., Battle Creek
Lowe, Stanley T.....231 North Ave., Battle Creek
Lund, C. A. E.....96 E. Jackson St., Battle Creek
Marino, Salvator G. (A).....VA Hospital, Lebanon, Pa.
McCuaig, Alfred G.....719 Capitol St. S.W., Battle Creek
McGee, John W.....105 Irwin Ave., Albion
Melges, Fredk. J.....25 W. Michigan Ave., Battle Creek
Mitton, Orland W. (R).....9026 Clairmont N.E., Albuquerque, N. Mex.
Morrison, Donald B.....719 Capital S.W., Battle Creek
Mullenmeister, H. F.....275 Capital N.E., Battle Creek
Murillo, Casmir.....235 North Ave., Battle Creek
Mustard, Russell L.....25 W. Michigan Ave., Battle Creek
Norgan, Anne F.....719 Capital Ave S.W., Battle Creek
Orr, Eli H. (A).....VA Hospital, Battle Creek
Parkinson, Chas. E.....Leila Hospital, Battle Creek
Patrick, Gilbert T.....25 W. Michigan Ave., Battle Creek
Pearson, Donald J.....255 North Ave., Battle Creek
Pier, Clarence T. (A).....VA Hospital, Battle Creek
Powell, C. E.....632 North Ave., Battle Creek
Powell, Donna (A).....VA Hospital, Ft. Custer
Power, John R.....140 Capital Ave. N.E., Battle Creek
Reizner, Bernard Z.....Oaklawn Hospital, Marshall
Robbert, John.....191 College, Battle Creek
Rorich, Wilma C. W. (R)....166 N.E. Capital, Battle Creek
Rowan, Russell C.....500 S. Ionia St., Albion
Royer, Clark W.....1331 W. Michigan Ave., Battle Creek
Ryan, Chas. J.....Leila Hospital, Battle Creek
Seifert, Charles (M)....6231 Peace Pipe, San Antonio, Texas
Sharp, Ara D. (R).....502 Irwin Ave., Albion
Shellenberger, H. M.....123 S. Jefferson, Marshall
Shipp, Leland P.....25 W. Michigan Ave., Battle Creek
Sibilsky, A. Clark (A).....106 Brewer Dr., Battle Creek
Simpson, Robt. S.....700 Capital Ave. S.W., Battle Creek
Slagle, Geo. W.....203 Capital Ave. N.E., Battle Creek
Spencer, Collis M.....308½ S. Superior St., Albion
Stadle, Wendall H. (R).....607 Jennings Landing, Gougac Lake, Battle Creek
Stephenson, C. D.....140 Capital Ave. N.E., Battle Creek
Stiefel, Richard A.....25 W. Michigan Ave., Battle Creek
Strohmenger, Frank J.....500 S. Ionia St., Albion
Taylor, Clifford B.....500 S. Ionia St., Albion
Tazelaar, Myron A.....219 N. Madison St., Marshall
Vander Kamp, Harry (A).....VA Hospital, Battle Creek
Vander Voort, Wm. V. (L).....Rt. 4, Hastings
Vaughn, Charles.....175 College, Battle Creek
Verity, Lloyd E.....1002 Security Tower, Battle Creek
Vetne, Gunnar.....725 Capital S.W., Battle Creek
Walker, Chas S.....709 W. Van Buren St., Battle Creek
Walters, John F.....163 North Ave., Battle Creek
Walters, Wm. D.....175 College St., Battle Creek
Wemmer, Keith S.....1472 W. Michigan Ave., Battle Creek
Wencke, Carl G. (L).....197 N. Washington, Battle Creek
Winslow, Sherwood B.....710 North Ave., Battle Creek
Worgess, Duane R.....799 Capital Ave. N.E., Battle Creek
Yannitelli, S. A.....710 North Ave., Battle Creek
Young, John R.....719 Capital Ave. S.W., Battle Creek
Zaplitny, R. B.....163 North Ave., Battle Creek
Zaplitny, Sophia (A).....34 Ardmoor, Battle Creek
Zheutlin, Bertram.....50 Adams St., Battle Creek
Zindler, Geo. A.....1201 Security Bk. Bldg., Battle Creek

CASS COUNTY MEDICAL SOCIETY (38)

Adams, Uriah M.....Marcellus
Clary, Rudolph I.....216 S. Front St., Dowagiac
Comstock, L. David, Jr.....417 W. High St., Dowagiac
Guzzo, Henry V.....110 W. Division St., Dowagiac
Hickman, John K.....108 W. Division St., Dowagiac
Loupee, Geo. E.....114 West St., Dowagiac
Loupee, Sherman L. (L).....108 Orchard, Dowagiac
Pierce, Frank L. (L).....142 S. Front St., Dowagiac
Pierce, Kenneth C.....417 W. High St., Dowagiac

CHIPPEWA-MACKINAC COUNTY MEDICAL SOCIETY (42)

Allott, Hugh R.....816 Ashmun St., Sault Ste. Marie
Bandy, Festus C. (R).....2431 Hamlin Lane, Sarasota, Fla.
Blair, H. Milton.....300 Court St., Sault Ste. Marie
Clausen, Claire H.....300 Court St., Sault Ste. Marie
Finlayson, Donald D.....301 E. Spruce St., Sault Ste. Marie
Hagele, Marie A.....126 Park Pl., Sault Ste. Marie
Haines, Ellen R.....Cedar Point, Mackinac Island
Hamel, Herbert E.....St. Ignace
Harrington, Harvey M. (L).....Box 319, Sault Ste. Marie
Howe, Donnell C., Jr.....300 Court St., Sault Ste. Marie
Mackie, Thos. B.....300 Court St., Sault Ste. Marie
McBryde, Lyman M.....416 Ashmun St., Sault Ste. Marie
Mertaugh, Wm. F.....104 W. Spruce St., Sault Ste. Marie
Montgomery, Benj. T.....812 Ashmun St., Sault Ste. Marie
Reddick, C. E.....Chippewa County Health Dept., Sault Ste. Marie
Rhind, Earl S.....Sault Polyclinic, Sault Ste. Marie
Scott, Dale.....816 Ashmun St., Sault Ste. Marie
Solomon, Joseph A.....Mackinac Island
Thompson, Chas. F.....Drummond Island
Trapasso, Tony J.....816 Ashmun, Sault Ste. Marie
Tygart, Robert L.....301 E. Spruce, Sault Ste. Marie
Venier, Anton G.....816 Ashmun St., Sault Ste. Marie
Wedding, Erling S.....203 Hudson Dr., Sault Ste. Marie

CLINTON COUNTY MEDICAL SOCIETY (46)

Bennett, Geo. W.....203 W. Main St., Elsie
Cook, Bruno C.....Westphalia
Elliott, Bruce R.....Box 369, Ovid
Fillinger, Wells B. (L).....Ovid
Foo, Chas. T. (L).....St. Johns
Grost, James M.....110 Oakland St., St. Johns
Henthorn, Arthur C. (L).....Box 216, St. Johns
Luton, Frank E. (L).....Beaver Island, St. James
Russell, Sherwood R.....104 N. Oakland St., St. Johns
Scott, James S.....De Witt
Sheline, Victor L.....Medical Center, Ithaca
Slagh, Earl M.....Elsie
Smith, Franklin W.....105 S. Ottawa St., St. Johns
Stephenson, Wesley F.....510 E. Walker St., St. Johns
Stoller, Paul F.....St. Johns

DELTA-SCHOOLCRAFT COUNTY MEDICAL SOCIETY (50)

Anderson, Francis C.....218 S. 10th St., Escanaba
Bernier, A. Barroso.....547 Michigan Ave., Manistique
Bash, Theodore L.....Bark River
Benson, Gilbert W. (A).....Ludington St., Escanaba
Boyce, Donald H.....1107 Ludington St., Escanaba
Cretens, Mary.....Delta Menominee Hth. Dept., Escanaba
Dehlin, James R.....8 S. 11th St., Gladstone
Fitch, Donald N.....804 Ludington St., Escanaba
Fyvie, James H.....202 S. Cedar St., Manistique
Gordon, E. James.....117 N. 22nd St., Escanaba
Groos, Harold Q.....1015 S. 1st Ave., Escanaba
Groos, Louis P.....1015 S. 1st Ave., Escanaba
Hockstad, Raymond .....804 Ludington St., Escanaba
Hult, Otto S.....1005 Delta Ave., Gladstone
Le Mire, Donald F.....1104 S. First Ave., Escanaba
Le Mire, William A.....1106 First Ave. S., Escanaba
Lindquist, Norman L.....205 S. Tenth St., Escanaba
Maniaci, Geo.....8 South 11th St., Gladstone
McInerney, Thos. A.....1221 Ludington St., Escanaba
Miller, Albert H. (L).....904 Wisconsin, Gladstone
Olson, Carl J.....8 S. 11th St., Gladstone
Ryde, Robt. E.....1221 Ludington, Escanaba
Theisen, Nikolaus J.....St. Francis Hospital, Escanaba
Waters, Duane L.....200 S. Cedar St., Manistique
Wehner, Merle E.....131 River St., Manistique
Whipple, Arno.....117 North 22nd St., Escanaba

DICKINSON-IRON COUNTY MEDICAL SOCIETY (54)

Addison, Earl R.....412 Superior Ave., Crystal Falls
Alexander, Wm. H.....411 East C St., Iron Mountain
Anderson, Donald T.....408 Hamilton Ave., Kingsford
Anderson, Robert.....804 Main St., Norway
Boyce, George H. (L).....First Natl. Bank Bldg., Iron Mountain
Carlson, Ralph E.....500 Stephenson Ave., Iron Mountain
Cecconi, R. D.....Commercial Bank Bldg., Iron Mountain
Cooper, Chas. A.....Box 542, Stambaugh
Gendzwell, Joyce.....805 Vulcan St., Iron Mountain
Gladstone, Wm. R., Jr.....804 Main St., Norway
Hayes, Willard N.....720 N. Main St., Norway
Huron, Willis H.....106 West B St., Iron Mountain
Irvine, Lionel E.....Box 438, Iron River
Jacobs, Donald J.....Ochiette Bldg., Iron Mountain
Kofmehl, Wm. J.....Stambaugh
McEachran, Hugh D.....500 Stephenson Ave., Iron Mountain
Nora, James C.....15 Eighth Ave., Iron River
Pieper, Ernest.....Iron Mountain
Retallack, Russell C.....326 W. Genesee St., Iron River
Schmutzler, Walter A.....373 Woodward St., Iron Mountain
Schroeder, John M.....Khoury Bldg., Iron Mountain
Smith, Donald R.....Box 471, Iron Mountain
Steinke, Chas. G.....517 Stephenson Ave., Iron Mountain
Stelle, Robert E.....412 Superior, Crystal Falls

EATON COUNTY MEDICAL SOCIETY (58)

Brown, Byron P.....339 S. Cochran, Charlotte
Carothers, Danl. J.....315 S. Cochran, Charlotte
Curtis, Keith L.....531 Foote St., Charlotte
De Land, C. Le Roy.....Olivet
Engle, Paul H. (A).....Olivet
Erhard, O. Stewart.....301 Rancho, Eaton Rapids
Garlock, Fred C.....406 E. Jefferson St., Grand Ledge
Harrod, Gordon R.....Grand Ledge
Joseph, Daniel D.....666 N. Sheldon St., Charlotte
Landick, Robt. E., Jr. (A).....Rt. 1, Charlotte
Matthews, R. W.....236 S. Main St., Charlotte
Meinke, Albert H., Jr.....702 S. Main, Eaton Rapids
Myers, Albert W.....Potterville
Passos, Benjamin A.....304 N. Cochran St., Charlotte
Riley, Jos. L.....201 S. Cochran St., Charlotte
Robinson, S. R.....1140 Willow St., Grand Ledge
Sevener, Lester G.....236 S. Main St., Charlotte
Sherman, Eber B.....P.O. Box 158, Eaton Rapids
Van Ark, Bert.....511 Hale, Eaton Rapids
Van Ark, Herman F.....Eaton Rapids
Willits, Clayton O.....127 Upland, Charlotte

GENESEE COUNTY MEDICAL SOCIETY (62)

Abbott, R. Roderick.....4101 Greenbrook Lane, Flint
Adams, Albert C.....G 7194 E. Court St., Davison
Adams, Burnell H.....609 S. Lynch St., Flint 3
Adams, Chester H.....410 S. Ballenger Hwy., Flint 4
Anderson, Harley H.....11820 N. Saginaw, Mt. Morris
Anderson, John L.....2765 Flushing Rd., Flint 4
Anderson, Robt. E.....420 S. Ballenger Hwy., Flint
Antell, Richard A.....2733 Crestwood Dr., Flint
Anthony, Geo. E. R.....1015 Detroit St., Flint 4
Baird, W. Claire.....2765 Flushing Rd., Flint
Bald, Fredk. W.....410 S. Ballenger, Flint 3
Barbour, David A.....5369 Briarcrest, Flint
Barbour, Fleming A.....2015 Lincoln Dr., Flint 3
Baske, Franklin W.....923 Maxine St., Flint 3
Basualdo, Carlos A. E. (A)....7th Fl. McLaren Hosp., Flint
Batdorf, Joseph T.....11325 S. Saginaw, Grand Blanc
Bateman, Lawrence G.....1928 Lewis St., Flint 6
Beck, Douglass R.....1450 Country View Lane, Flint 7
Becker, Eugene B.....2765 Flushing Rd., Flint 4
Bendush, Cecil L.....806 W. 6th Ave., Flint
Benkert, Jack.....6211 Lake Forest Dr., Grand Blanc
Benson, John C.....402 W. 2nd St., Flint 3
Berman, Harry.....3309 Fenton Rd., Flint 7
Berner, Gerald P.....2765 Flushing Rd., Flint
Bernstein, Eli N.....311 E. Court St., Flint
Best, J. A.....3803 Clio Rd., Flint 4
Beyer, George D.....G 3337 W. Vienna, Clio
Bishop, Don L.....2226 Detroit St., Flint 5
Bogart, Leon M. (L).....503 National Bldg., Flint
Bolduc, Gregoire.....325 E. First St., Flint
Boles, Wm. P. (L).....714 Beach St., Flint 3
Bosker, Donald.....1620 N. Franklin, Flint 3
Bota, Robert A.....1623 Montclair, Flint
Boyer, Peter R.....100 Medical Arts Bldg., Flint
Bradley, Robt. M.....1112 Mott Fdn. Bldg., Flint 2
Brain, Roy G. (L).....460 S. Saginaw St., Flint 3
Branch, Hira E.....821 Mott Fdn. Bldg., Flint
Brasie, Donald R. (R).....310 Josephine St., Flint 4
Briggs, Guy D. (L).....224 E. Court St., Flint 3
Brown, Clarence A.....1601 Woodlawn Pk. Dr., Flint 7
Bryant, Donald R.....621 Mott Fdn. Bldg., Flint
Buchanan, Gerald S.....211 S. Saginaw St., Holly
Buchanan, Wm. F.....238 W. Caroline, Fenton
Burkett, Leslie V.....121 E. 7th St., Flint 3
Cassan, Stanley M.....311 E. Court St., Flint
Chambers, Myrton S.....3402 Westwood Pkwy., Flint 3
Chase, Wm. D.....1318 N. Ballenger Hwy., Flint 4
Clark, Robt. L.....1301 Flushing Rd., Flint 4
Collins, James I.....G 1128 N. Dye Rd.,Flint
Colwell, Clifford W.....328 S. Saginaw St., Flint 3
Conover, Geo. V.....207 Genesee Bank Bldg., Flint 2
Cook, Frank W.....208 Genesee Bank Bldg., Flint
Cook, Henry (L).....208 Genesee Bank Bldg., Flint 2
Cook, John L.....813 Mott Fdn. Bldg., Flint 7
Coriasso, Louis B.....1515 W. Atherton Rd., Flint 4
Coyne, K. M.....2765 Flushing Rd., Flint
Craig, William G.....G. 3176 W. Court St., Flint
Cross, Robert L.....6029 Marja, Flint

Curry, Geo. J. (L).....346 S. Saginaw St., Flint 3
Cutler, G. Campbell.....420 S. Ballenger, Flint 4
Davis, Robt. C.....G 3029 Flushing Rd., Flint 4
Dawson, Ralph E.....721 W. Sixth Ave., Flint 4
Day, John Murray.....721 W. Sixth Ave., Flint 4
Delzingro, Nicholas (L).....328 Main St., Davison
Dettman, Carlton K.....12023 N. Seymour, Montrose
Dickstein, Bernard.....605 National Bldg., Flint 3
Diggs, Roy D., Jr.....5001 N. Saginaw St., Flint
Dismond, Samuel R.....1402 S. Saginaw St., Flint
Dodds, Fredk. E. (L).....1336 Lewis St., Flint 6
Dodds, Max E.....625 S. Grand Traverse, Flint
Dooley, James F.....1609 Brookwood Dr., Flint 3
Dorsey, Philip W.....2759 Bennett Valley Rd., Santa Rosa, Calif.
Drewyer, Glenn E.....2001 Colchester, Flint 3
Dwyer, William F.....625 S. Grand Traverse, Flint
Dykewicz, Richard A.....2768 Flushing Rd., Flint 4
Eaton, Wayne L.....2765 Flushing Rd., Flint
Eichhorn, Ernest M.....2765 Flushing Rd., Flint 4
Eickhorst, Thos. N.....2765 Flushing Rd., Flint 4
Elliott, Hardie B.....503 S. Saginaw St., Flint 3
Engelman, Raymond M.....103 Medical Arts Bldg., Flint 4
Ettinger, Ralph D.....238 W. Caroline St., Fenton
Failing, John F., Jr.....Hurley Hospital, Flint
Fan, Q. C.....2002 E. Court St., Flint
Farah, Ben S.....2765 Flushing Rd., Flint 4
Farhat, Maynard M.....505 W. Court St., Flint
Fee, Manson G.....108 E. Kearsley St., Flint 3
Finkelstein, Theo.....1415 Broadway Blvd., Flint 6
Fitch, Robert E.....1005 Leith, Flint 2
Forrer, Graydon R.....2279 E. Grand Blanc Rd., Grand Blanc
Fuller, Harvey T. (R).....820 Genesee St., Mt. Morris
Gilbert, David H. (A).....39FA 1st MSL Bn., APO 165, New York, N. Y.
Goering, George R. (L).....2601 Norbert, Flint
Goetz, Margarete M. (A).....420 Genesee Bank Bldg., Flint
Goetz, Rudolph.....1221 Church St., Flint
Golden, Evelyn.....218 E. Court St., Flint
Golden, H. Maxwell.....218 E. Court St., Flint 3
Goodfellow, Benj. T. (L).....141 Davis Lake Rd., Lapeer
Gorne, Saul S.....619 Clifford St., Flint 3
Griffin, Ernest P., Jr.....1505 Arrow Lane, Flint 7
Grommons, Jack R.....721 W. Sixth Ave., Flint
Grover, Harold F.....601 S. Saginaw St., Flint 3
Guile, Gurdon S.....1621 DuPont St., Flint 4
Gullekson, Edwin H.....1917 Lynbrook Dr., Flint
Gumpper, C. R.....4437 Morrish Rd., Swartz Creek
Gundry, Geo. L. (L).....Grand Blanc
Gutow, Isadore H.....2765 Flushing Rd., Flint 4
Gutow, Julius J.....726 Church St., Flint
Gutow, Richard F.....203 Medical Arts Bldg., Flint
Gutowitz, Erwin.....420 S. Ballenger Hwy., Flint
Guyon, Joseph F.....302 W. Pierson, Flint
Guyon, Mary A.....302 W. Pierson Rd., Flint 5
Hackley, Richard D.....3942 Western Rd., Flint
Hague, Robt. F.....210 E. Court St., Flint 3
Hallitt, John Wm.....102 Medical Arts Bldg., Flint
Harper, Robt. H.....713 Thomson St., Flint 3
Harris, Bernard J.....1750 Lynbrook, Flint
Harris, Donald R.....2429 Welch Blvd., Flint
Hauser, Fredk. V.....1015 Mott Fndn. Bldg., Flint 2
Hawkins, James E.....4618 Roberts St., Flint
Heine, John.....302 Medical Arts Bldg., Flint
Heinemann, Herman J.....G7316 Calkins Rd., Flint 7
Helcher, Phyllis O.....G5303 Flushing Rd., Flushing
Hennessy, Charles R.....517 Mott Fndn Bldg., Flint
Hing, N. Wm.....326 Stockdale St., Flint 5
Hiscock, Harold H.....503 S. Saginaw St., Flint 3
Hockman, Thomas A.....11125 Old Bridge Rd., Grand Blanc
Hodges, Frank V.....Hurley Hospital, Flint 2
Hollis, John W.....Fisher Body Div., Grand Blanc
Hooper, Virgil R.....4230 Trumbull, Flint
House, Robert J.....3133 Mackin Rd., Flint
Hubbard, Wm. B.....1205 Maxine St., Flint 3
Hubbard, Wm. C.....302 Paterson Bldg., Flint
Hufton, Wilfrid L.....2765 Flushing Rd., Flint 4
Hunt, Richard J.....6259 Lake Forest Dr., Grand Blanc
Hurd, Clayton E.....205 Lincoln, Fenton
Irish, Lawrence R.....346 Allendale Pl., Flint
Jacoby, John S.....4300 S. Saginaw St., Flint
James, Robt. E.....1515 W. Atherton, Flint
Johnson, A. H., Jr.....3219 North St., Flint 5
Johnson, Frank D.....625 S. Grand Traverse, Flint
Johnson, Raymond E.....5173 W. Reid Rd., Swartz Creek
Jordan, Paul H.....1125 Jordan Lane, Rt. 2, Grand Blanc 8
Judd, Alvin E.....1620 N. Franklin, Flint 6
Karr, Paul H. (M).....4026 Newport, Omaha, Nebr.
Kaufman, Lewis D.....4002 N. Saginaw St., Flint 5
Kelly, James E.....2765 Flushing Rd., Flint
Kimbrough, C. B.....1402 S. Saginaw St., Flint 3
Kirsten, Walter T.....809 S. Ballenger, Flint
Kitto, Harold J.....902 Stockdale, Flint
Kline, O. F.....2765 Flushing Rd., Flint 4
Knapp, Wm. D.....503 S. Saginaw St., Flint 3
Knoblich, Roman R.....Hurley Hospital, Flint
Koop, Chester S.....(Address Unknown)
Kretchmar, Arthur H.....625 S. Grand Traverse, Flint
Kurtz, John J. (L).....601 S. Saginaw St., Flint 3
Laird, James I.....12010 Kipp Rd., Goodrich
Laurel, Richard J.....410 S. Ballenger Hwy., Flint
La Vielle, Carroll J.....Hurley Hospital, Flint
Leach, J. Leonidas.....5014 N. Saginaw St., Flint
Le Mieux, Leslie L.....701 W. Dayton St., Flint 4
Levine, Mark C.....721 W. 6th Ave., Flint
Lewis, Thos. E.....4071 Richfield Rd., Flint
Lewis, Vivian M.....167 E. Hamilton Ave., Flint
Lightfoot, Arthur S.....4500 Detroit St., Flint
Limbach, David R.....900 Begole St., Flint 2
Lindman, Thomas C.....2484 Nolen Dr., Flint
Livesay, Jackson E.....503 S. Saginaw St., Flint 3
Lundeen, Richard M.....3393 Clio, Flint
Lusk, John A.....9233 W. Davison Rd., Davison
Lyttle, Sydney N.....503 S. Saginaw St., Flint 3
MacGregor, Delbert M.....701 W. Dayton St., Flint 4
MacKenzie, J. W., Jr.....4437 Morrish Rd., Swartz Creek
Macksood, Albert J.....3169 W. Pierson Rd., Flint
Macksood, Jos. A.....3169 W. Pierson Rd., Flint 4
Macksood, William E.....3169 W. Pierson Rd., Flint
MacPhail, Albert A.....1819 Park Forest Dr., Flint
Mangelsdorf, C. H.....4122 Brownsell, Flint
Manwaring, John T.....1654 Seminole St., Flint 3
Markunas, Paul J.....4002 N. Saginaw St., Flint
Martin, James A.....822 S. LeRoy, Fenton
Mathias, Berton J.....1301 Flushing Rd., Flint 4
McAlindon, J. D.....1601 Euclid, Flint
McClellan, Junius W.....Buick Motor Division, Flint 7
McGarry, Roy A. (L).....601 S. Saginaw St., Flint 3
McGregor, Allan R.....G 3337 W. Vienna Rd., Clio
McLeod, Kenneth W. A.....2765 Flushing Rd., Flint 4
McMurray, Richard J.....2765 Flushing Rd., Flint
McTaggart, David.....625 S. Grand Traverse, Flint
Mendes, Peter C. (A).....11117 116th St., Edmonton, Alta., Canada
Mendrek, H. H.....1639 Mott Fdn. Bldg., Flint 2
Michael, Sidney R.....922 Welch Blvd., Flint 4
Michels, Robt. M. (A).....409 McKinley Rd., Flushing
Michelson, Richard B.....2014 Robt T. Longway, Flint 3
Miller, Loren E.....2645 Corunna Rd., Flint 3
Miltich, Anthony J.....915 S. Grand Traverse, Flint 3
Moeller, Jan C.....3802 Brentwood Dr., Flint
Moore, Glenn E.....323 W. Second, Flint 3
Moore, Wesley P. (A).....802 Tilden, Flint 5
Morin, Paul.....1968 Miller Rd., Flint
Morrison, Wm. H.....11610 Hazel St., Grand Blanc
Morrissey, Vaughn H.....101 Stockdale St., Flint 4
Mosier, Edward C.....115 Lake St., Otisville
Murphy, E. Grant.....1825 Chelsea Circle, Flint 3
Newman, Harry S.....816 E. Court St., Flint
Nicholls, Wm. W.....806 W. Sixth Ave., Flint 3
Nitz, Donald A.....1515 W. Atherton Rd., Flint
Odle, Ira D. (L).....Welch Blvd., Flint 4
Oldt, Mary Ruth.....602 S. Lynch St., Flint 3
Orr, John W. (L).....Orrs Pt. Lk. Fenton, Fenton
Osher, Seymour L.....315 E. Court St., Flint 3
Parliament, Burt A.....314 Ferndale Pl., Flint 3
Pfeifer, Archibald C. (L).....12205 N. Saginaw Rd., Mt. Morris
Phelps, Lynn A.....10122 Janaroy Ct., Goodrich
Phillips, A. F.....X-Ray Dept. Hurley Hosp., Flint
Pickering, Woodrow H.....1602 Ballenger Hwy., Flint 4

Pike, Wallace W.....7514 Miller Rd., Swartz Creek
Platt, Alice Lee (A).....1430 Eldorado Dr., Flint
Portney, Jack E.....725 Stevens St., Flint 3
Pougnet, W. D.....6155 Maple Ridge, Flint
Pratz, Oliver C.....1303 Detroit St., Flint 4
Preston, Otto J.....300 N. Chevrolet Ave., Flint 2
Prior, Richard W.....1266 S. Le Roy, Fenton
Purcell, F. L.....Ternstedt Plant, Flint 5
Quin, John, Jr.....2765 Flushing Rd., Flint 4
Ragan, Russell M.....2768 Flushing Rd., Flint
Rapport, Richard L.....503 S. Saginaw, Flint 3
Rathburn, Robert J.....1501 Flushing Rd., Flint
Rawling, John C.....115 Med. Arts Bldg., Flint 4
Rawlings, J. Mott.....1601 Neome Dr., Flint 3
Reid, John H.....1301 Flushing Rd., Flint 4
Reye, George H.....2279 E. Grand Blanc Rd., Grand Blanc
Rieth, Geo. F.....1406 Davison St., Flint 6
Roberts, Floyd A. (L).....327 Sheffield, Apt. 281, Flint 3
Roth, F. Dale.....606 Mott Fdn. Bldg., Flint
Rowe, John B.....653 Saginaw St., Flint 3
Rulney, Max.....2765 Flushing Rd., Flint 4
Rundles, Walter Z., Jr.....500 Grand Traverse St., Flint 3
Rundles, Walter Z.....500 Grand Traverse St., Flint 3
Sandberg, Russell G.....2030 Pierce St., Flint 3
Sande, C. W. (A).....Northwood, No. Dak.
Sanocki, Fredk. E.....1651 Detroit St., Flint 3
Saunders, Jack (A).....20 Doctors Lane
King City, Ont., Canada
Scavarda, Chas. J.....1106 Maxine, Flint
Schiff, Benton A.....323 W. 2nd St., Flint 3
Schmidlin, Robt. W.....3710 Davison Rd., Flint 6
Schreiber, E. Oskar.....2765 Flushing Rd., Flint 4
Schroeder, Paul E.....1673 N. Chevrolet, Flint
Schultz, J. Stanley.....3327 Fleming Rd., Flint 4
Schwartz, John M.....1300 N. Dort Hwy., Flint
Schwarz, Heinz H.....1430 Eldorado, Flint
Scott, Robt D. (L).....1215 Detroit St., Flint 4
Seven, Phillip G.....2301 Cummings, Flint
Seymour, Geo. D.....G7237 N. Saginaw, Mt. Morris
Shantz, Leighton O.....1497 Country View Lane, Flint 3
Sheeran, Danl. H. (A).....610 S Vernon Ave., Flint 3
Sherwood, Frederick.....2765 Flushing Rd., Flint 4
Simoni, Lewis E.....3210 S. Dort Hgwy, Flint 7
Sirna, Anthony R.....11219 Stonybrook, Grand Blanc
Smith, Eugene C.....606 Stevens, Flint
Smith, Harold O.....1952 Miller Rd., Flint 3
Smith, Maurice J.....2801 N. Saginaw St., Flint 5
Smith, Sidney E.....625 S. Grand Traverse, Flint
Sniderman, Benj. F.....727 Beach St., Flint 3
Snyder, Chas. E.....8129 Miller Rd., Swartz Creek
Solik, A. E. (M).....(Address Unknown)
Sorkin, Morris L.....718 Beach St., Flint 2
Sorkin, Saml. S.....718 Beach St., Flint 2
Sparks, Harvey V.....2765 Flushing Rd., Flint 4
Steffe, Ralph S.....2765 Flushing Rd., Flint 4
Steinman, Floyd H.....503 S. Saginaw St., Flint 2
Stevens, Philip K.....1116 Mott Fdtn. Bldg., Flint
Stevenson, Wm. W. (L).....108 E. Kearsley St., Flint 3
Streat, Rudolph W. (L).....218 E. 8th St., Flint 3
Stroup, Clayton K.....2002 E. Court St., Flint 3
Sullivan, M. R.....1510 Forest Hill, Flint
Sutherland, James K.....402 E. 3rd St., Flint 3
Sutton, Geo. D. (L).....303 W. Court St., Flint 3
Tauscher, John W.....2016 R. T. Longway Blvd., Flint
Theuerle, Walter I.....3101 N. Saginaw St., Flint 5
Thompson, Charles A.....4211 Comstock St., Flint 4
Thompson, Jack W.....2702 Flushing Rd., Flint 4
Thoms, Peter S.....1279 W. Coldwater Rd., Flint
Thorburn, Grant (L).....Box 387, Waynesboro, Pa.
Tofteland, Elmer H.....2765 Flushing Rd., Flint 4
Tower, Rita B. (L).....2801 S. Dort Hwy., Flint 7
Turcke, Allen F.....5717 Marja St., Flint 5
Turner, Merald G.....G 3169 W. Pierson, Flint 2
Tuuri, Arthur L.....Mott Children Clinic, Flint
Urich, Vernon.....1315 Mott Fndt. Bldg., Flint 2
Van Duyne, Fredk. W.....2849 Miller Rd., Flint
Van Harn, Raymond S.....1651 Detroit St., Flint 5
Varney, Howard L.....724 East St., Flint
Vaughan, Edgar J.....Linden
Wade, Franklin V.....1121 Mott Fndt. Bldg., Flint
Walker, James D.....11325 S. Saginaw St., Grand Blanc
Walter, Daniel L.....820 Davison Rd., Davison
Ward, Nell M. (L).....503 S. Saginaw St., Flint 3
Weber, Robt. M.....3710 Davison Rd., Flint 6
Webster, Robt. M. (A).....5 Lee St., Newman, Ga.
Wentworth, John E.....420 S. Ballenger, Flint 4
Werness, Inga W. (L).....220 E. Fourth St., Flint
Wheeler, J. D.....2470 Nolen, Flint
White, Carl H.....106 River St., Fenton
White, Frank T.....5492 Lapeer Rd., Flint
Whites, Jack C.....7343 Flushing Rd., Flushing
Willard, Robt. H.....718 Beach St., Flint 3
Williams, T. Wendell.....5003 N. Saginaw, Flint
Williams, Wm. S. (L).....5216 S. Genesee, Grand Blanc
Willis, Robert E.....6606 N. Saginaw St., Flint
Willoughby, L. L. (L).....1127 S. Water St., Marine City
Wills, Thos. N. (R).....(Address Unknown)
Wolcott, Nan D.....7506 Lapeer Rd., Davison
Wolf, Melvyn D.....318 Medical Arts Bldg., Flint
Woodsides, K. T.....7343 Flushing Rd., Flushing
Wright, Donald R.....326 W. Court St., Flint
Wynia, Robert E. (A).....2301 12th Ave. S.,
Great Falls, Mont.
Zeis, Myron G.....718 Beach St., Flint 2
Zelko, Daniel M.....4071 Richfield Rd., Flint

GOGEBIC COUNTY MEDICAL SOCIETY (66)

Albert, S. G.....103 Suffolk St., Ironwood
Davidson, Donald L.....200 S. Sophie St., Bessemer
Franck, John R., Jr.....401 Sunday Lake, Wakefield
Gallo, Bela.....Newport Clinic, Ironwood
Gertz, Michael A.....109 E. Aurora St., Ironwood
Gorilla, Allen C.....210 Suffolk St., Ironwood
Harrington, Rex R., Jr.....104 E. Ridge St., Ironwood
Lieberthal, M. J. (L).....124 E. Gogebic, Ironwood
Lieberthal, Paul R.....Box 632, Ironwood
Medford, Lester.....306 Sunday Lake St., Wakefield
Murphy, Percy J.....Seaman Bldg., Ironwood
Santini, Florian J.....109 E. Aurora St., Ironwood

GRAND TRAVERSE-LEELANAU-BENZIE COUNTY MEDICAL SOCIETY (70)

Beall, John G.....1105 E. Front St., Traverse City
Behan, Gerald W.....Box C, Traverse City
Bolan, Ellis J.....Suttons Bay
Brownson, Kneale M.....116 Cass St., Traverse City
Bushong, Benjamin B.....116 Cass St., Traverse City
Cajigas, Tomas R.....J. D. Munson Hospital, Traverse City
Campbell, Thomas D.....Box C, Traverse City
Cartwright, Wm. H.....1105 E. Front St., Traverse City
Christie, Joseph.....Northport
Clark, Oswald V.....Ramsdell Rd., Traverse City
Cline, Theodore N.....999 6th, Traverse City
Cline, Warren W.....999 6th, Traverse City
Coleman, John F.....909 S. Maple, Traverse City
Curran, Cyril J.....Box C, Traverse City
Doolittle, John E.....9 S. St. Joseph Ave., Niles
Dundon, Arthur F.....Box C, Traverse City
Edmonds, W. T.....Munson Hospital, Traverse City
Ellis, Claude I.....Suttons Bay
Ferguson, John T.....Box C, Traverse City
Fiebing, Jack A.....P.O. Box 283, Traverse City
Fishbeck, Wm. A.....1209 E. 8th St., Traverse City
Goodrich, Dwight (R).....601 W. Front St., Traverse City
Haberlein, Chas. R.....1100 Sixth St., Traverse City
Hall, James W.....1100 Sixth St., Traverse City
Hamilton, Earl E.....530 S. Union St., Traverse City
Herkner, Mildred L.....119 Barlow St., Traverse City

Hubbell, Reader J.....228 S. Madison, Traverse City
Huene, Nevin.....110 E. Front St., Traverse City
Huston, R. R. (L).....Elk Rapids
Johnston, James D.....1100 Sixth St., Traverse City
Kamp, Robt. L.....Beulah
Kaufman, James N.....427½ Main St., Frankfort
Kitti, Wm. W.....Kalkaska
Komesu, Seiichi.....Box C, Traverse City
Lemen, Charles E.....110 S. Madison, Traverse City
Lieding, Keith G.....7844 Peninsula Dr., Traverse City
Lossman, Robt. T.....J. Decker Munson Hosp., Traverse City
McClay, Adam C.....6330 Peninsula Dr., Traverse City
Michael, Stanley L.....335 Davis St., Traverse City
Milliken, John G.....224 Circle Dr., Traverse City
Nickels, Mervyn M.....Box C, Traverse City
Norconk, Alonzo A.....Empire
Olsen, William R.....1100 Sixth St., Traverse City
Pelto, Maurice S.....Munson Hospital, Traverse City
Peterson, Wm. D.....876 E. Front St., Traverse City
Pike, Donald G.....1105 E. Front St., Traverse City
Ponczek, E. J.....Box C, State Hospital, Traverse City
Power, Frank H.....116 Cass St., Traverse City
Salon, Dayton D.....108 E. Front St., Traverse City
Schroeder, Dwight M.....Northport
Skendzel, L. P.....Munson Hospital, Traverse City
Sladek, Edward F.....123 E. Front St., Traverse City
Sommerness, M. Duane.....Box C, Traverse City
Sorum, F. T.....Box C, Traverse City
Spencer, John R.....1124 E. Front St., Traverse City
Steffey, Jos. C.....116 Cass St., Traverse City
Stokes, G. Edward.....1100 Sixth St., Traverse City
Swartz, Fred G. (L).....612 Sixth St., Traverse City
Sweeney, Bernard J.....1100 Sixth St., Traverse City
Thacker, Fredk. R.....Front St., Frankfort
Thirlby, Edwin L. (L).....116 Cass St., Traverse City
Thirlby, Richard L.....228 S. Madison, Traverse City
Wagener, Creighton A.....1100 Sixth St., Traverse City
Weih, Jack E.....1105 E. Front St., Traverse City
Weitz, Harry L.....Munson Hospital, Traverse City
Wilcox, Paul H.....333 Sixth St., Traverse City
Wiley, Philip K.....116 Cass St., Traverse City
Williams, Chas. R.....416 Sixth St., Traverse City
Willoughby, Gordon W.....408 Main St., Frankfort
Wolfgram, Lavern V.....1089 E. 8th St., Traverse City
Wonacott, R. G.....107 Dexter, Elk Rapids
Wright, J. K., Jr.....1105 E. Front St., Traverse City
Wunsch, Richard E.....1122 E. Front St., Traverse City
Young, John Harley.....Box C, Traverse City
Young, Lloyd B.....Route 2, Suttons Bay
Zielke, Irwin H.....106 S. Madison, Traverse City
Zimmerman, Jos. G.....102 W. Front St., Traverse City

GRATIOT-ISABELLA-CLARE COUNTY MEDICAL SOCIETY (74)

Aldrich, Alfred L.....Ithaca
Baker, Jerald F.....1127 E. High St., Mt. Pleasant
Barstow, Donald K.....215 W. Saginaw, St. Louis
Bauer, A. Robert, Jr.....412 E. Broadway, Mt. Pleasant
Becker, Myron G.....Edmore
Bedo, Andrew V.....802 Gordon, Mt. Pleasant
Bergin, Jos. H.....112 E. Superior, Alma
Binning, Griffith.....1328 N Drive, Mt. Pleasant
Brenner, E. J.....Central Mich. Comm. Hosp., Mt. Pleasant
Budge, Melvin J. (L).....1035 Jefferson, Ithaca
Burt, Loren G.....510 Prospect St., Alma
Chamberlain, Ray W.....608 E. Chippewa, Mt. Pleasant
Chamichian, Souren L.....Canal Rd., Mt. Pleasant
Davis, Lionel L.....314 S. Brown St., Mt. Pleasant
Dunlop, Donald.....301 East Fourth St., Clare
Fishbaugh, Wm. F., Jr.....3765 Woodmere, Alma
Gervin, Irfan S.....231 East End St., Alma
Graham, Bernard J.....510 Prospect Ave., Alma
Haddad, T. E.....207 N. Franklin St., Mt. Pleasant
Hammerberg, Kuno.....622 McEwan, Clare
Harrigan, Wm. L.....412 E. Broadway, Mt. Pleasant
Hedges, Frank W.....215 W Saginaw, St. Louis
Hersee, Wm. E.....306 S. College, Mt. Pleasant
Hobbs, A. Deane (R).....Box 3233 Florence Vill., A Sta., Winter Haven, Fla.
Hoogerland, C. L.....226 N. State St., Alma
Johnson, Frank D.....806 E. Bellows, Mt. Pleasant
Johnson, Philip R.....206 S. College Ave., Mt. Pleasant
Johnson, Robert B.....120 S. St. Johns St., Ithaca
Juhnke, LeRoy W.....314 S. Brown St., Mt. Pleasant
Kim, S. J.....CMC Hospital, Mt. Pleasant
Leff, Wenzel A.....1332 North Dr., Mt. Pleasant
Linn, Michael R.....Gratiot Med. Arts Bldg., Alma
Lusis, Alexsandrs.....St. Home & Tr. School, Mt. Pleasant
McArthur, Stewart C.....Box 32, Rosebush
McCoy, F. E.....Mercy Hospital, Williston, N. Dak.
Oldham, Earle S.....Breckenridge
Pease, Horace B.....Health Unit, CMU, Mt. Pleasant
Rank, Robert K.....Central Comm. Hospital, Mt. Pleasant
Ringer, Paul H., Jr.....314 S. Brown St., Mt. Pleasant
Roth, Wm. J.....303 W. Superior, Alma
Rottschaefer, John L.....3580 Northlawn Pk., Alma
Sanders, Jack F.....Mich. Masonic Home, Alma
Scott, Lincoln B., Jr.....417 S. College, Mt. Pleasant
Silvert, Pasche P.....Vestaburg
Smith, Dennis V. (L).....Box 99, Farwell
Soriano, D. A.....218 W. High St., Mt. Pleasant
Veldhuis, Andrew H.....801 Gordon Rd., Mt. Pleasant
Von Lackum, L. F.....535 Prospect Blvd., Waterloo, Iowa
Waggoner, Richard L.....120 N. Center St., St. Louis
Wallman, C. Harry.....901 State St., Alma
Wickert, Leo R.....1001 Watson Rd., Mt. Pleasant
Wilcox, Rex A.....525 State St., Alma
Wilson, Earl C.....Harrison
Wohlfeil, Dwayne L.....5851 Golfside Dr., Alma
Wolfe, Kenneth P.....510 Prospect Ave., Alma
Wood, Cornelius B.....207 N. Franklin St., Mt. Pleasant
Wood, John M.....1300 S. Watson Rd., Mt. Pleasant

HILLSDALE COUNTY MEDICAL SOCIETY (78)

Bates, Morton P.....110 S. Manning, Hillsdale
Davis, William B.....55 Barry, Hillsdale
Day, Luther W.....Grosvener Bank Bldg., Jonesville
Gates, Jon H.....379 S. Broad, Hillsdale
Henelt, Edmond.....32 S. Broad, Hillsdale
Hodge, Chas. L.....Reading
MacNeal, John A.....379 S. Broad, Hillsdale
Mattson, H. Frazyer.....32 S Broad St., Hillsdale
Peterson, Carl A.....59 Barry St., Hillsdale
Reigle, Frederick C.....Litchfield
Sawyer, Walter W.....61 N. Howell St., Hillsdale
Smith, Clark B.....379 S. Broad St., Hillsdale
Stein, Arthur J.....144 Budlong St., Hillsdale
Strom, Arthur W.....32 S. Broad St., Hillsdale
Tarr, John.....Camden
Trapp, Donald G.....32 S. Broad St., Hillsdale
Wiggins, Ira W.....Jonesville

HOUGHTON-BARAGA-KEWEENAW COUNTY MEDICAL SOCIETY (82)

Albright, John G.....220 Iroquois St., Laurium
Aldrich, Addison B.....325 Harris Ave., Hancock
Aldrich, Leonard C.....301 Quincy St., Hancock
Goodreau, Paul G.....301 Quincy St., Hancock
Hillmer, Raymond E. (L).....Painsdale
Hosking, Fredk. S.....322 Calumet St., Lake Linden
Janis, Anton J.....208 Quincy St., Hancock
Kolb, Fredk. E.....128 Calumet Ave., Calumet
LaBine, Alfred (L) Masonic Bldg.....Houghton
Lanczy, Tamas O.....Baraga County Hospital, L'Anse

Larson, Forrest W.....322 Shelden, Houghton
Lepisto, Victor E.....238 Quincy St., Hancock
Levin, Simon (L).....Huron Bldg., Houghton
Parker, Thomas M.....St. Joseph Hospital, Hancock
Potter, Earl C. (R).....1443 Crestridge Dr., Silver Springs, Md.
Repola, Kenneth L.....401 Isle Royale St., Laurium
Roche, Andrew M.....221 5th St., Calumet
Rowe, Kenneth E.....107½ Calumet Ave., Calumet
Sandell, Samuel T.....210 Center St., Hancock
Sloan, Paul S.....609 Sheldon Ave., Houghton
Stallard, C. W., Jr.....305 Tamarack St., Laurium
Stroube, John A.....522 W. Third, L'Anse
Williams, Marshall S.....St. Josephs Hospital, Hancock
Winkler, Henry J.....Box 461, L'Anse

HURON COUNTY MEDICAL SOCIETY (86)

Dixon, Ralph C.....Box 77, Pigeon
Elliott, Chas. S.....Pigeon
Gettel, Roy R.....Bad Axe
Herrington, C. Clark.....117 S. Port Crescent, Bad Axe
Herrington, Chas. I.....Bad Axe
Herrington, K. B.....317 Port Crescent, Bad Axe
Herrington, Willet J.....Bad Axe
Mullaney, J. M., Jr.....108 S. Port Crescent, Bad Axe
Oakes, Chas. W., Jr.....Harbor Beach
Scheurer, Clare A.....Pigeon
Sidagis, Joseph.....6 W. Main St., Sebewaing
Sorensen, Maurice G.....P. O. Box, Elkton
Steinhardt, Edward E.....Box 15, Elkton
Thompson, David H.....117 S. Port Crescent, Bad Axe
Turner, Phillip R.....230 S. First St., Harbor Beach
Wible, Chas. F., Jr.....Sebewaing
Willits, Robert A.....193 N. Main St., Elkton

INGHAM COUNTY MEDICAL SOCIETY (90)

Agate, Geo. H.....Mich. Dept. of Health, Lansing
Aiken, Donald J.....Grandview & Grand Rv., Okemos
Alexander, Reuben G.....301 Seymour Ave., Lansing 15
Allen, Robert E., Jr. (M).....1211 W. Main St., Lansing
Allis, Harry D.....1322 E. Michigan, Lansing
Altland, J. K.....Route 2, Box 178, Lansing
Altman, Harold (A).....Univ. of Missouri, Columbia, Mo.
Asselin, David C.....1322 E Michigan, Lansing
Badgley, Waldo O.....M.O. Box 756, Lansing 6
Baker, Thos. C.....624 N. Capitol Ave., Lansing
Bassett, Robt. C.....1322 E. Michigan Ave., Lansing 12
Bates, Richard.....2909 E. Grand River, Lansing
Bauer, Theodore I.....810 Mich. Nat. Tower, Lansing
Beaubien, Mark S. (A).....1006 Wildwood Dr., E. Lansing
Behen, Wm. C. (L).....535 S. Capitol Ave., Lansing
Behney, Charles A. (L).....Box 4256 San Jose Dr., Bisbee, Ariz.
Bellinger, Ernest G. (L).....Masonic Home, Alma
Berden, Eleanor A.....2630 Libbie Drive, Lansing 17
Berge, Richard E. (A).....1618 S. Genesee, Lansing 15
Bergeon, Milton C.....302 S. Steele St., Mason
Bevez, Frank L.....3209 S. Cambridge Rd., Lansing
Bingham, B. Wayne.....1034 E Saginaw, Lansing 6
Black, Chas. E.....112 W. Allegan, Lansing
Black, Gertrude C. K.....529 W. Grand River, Williamston
Blair, Thomas C.....1322 E. Michigan Ave., Lansing
Bleil, Eugene E.....1322 E. Michigan Ave., Lansing
Boylan, Rowan C.....Sparrow Hospital, Lansing
Bradford, Carl W.....301 Seymour, Lansing
Breakey, Robt. S. (R).....520 Westmorland, Lansing 15
Briggs, James.....2132 N. Cedar St., Holt
Brown, Fredk. W., Jr.....831 N. Washington Ave., Lansing
Brown, Joseph C.....790 E. Columbia, Mason
Brubaker, Earl W.....103 N. Washington Ave., Lansing 16
Bruegel, Oscar H. (L)....204 Birchwood Dr., Traverse City
Budden, M. Arthur.....2909 E. Grand River, Lansing
Burge, Terry E.....2132 N. Cedar, Holt
Burhans, Robt. A.....810 Mich. Nat'l Tower, Lansing
Burt, Emma G.....General Delivery, Agana, Guam
Cairns, Donald A.....136 W. Ash St., Mason
Calomeni, Anthony D.....309 Seymour Ave., Lansing 15
Carlson, Ralph G.....225 S. Waverly, Lansing 17
Carr, Earl I.....300 W. Ottawa St., Lansing
Caruso, Joseph A.....2909 E. Grand River, Lansing
Casey, Byron L.....202 M.A.C., East Lansing
Chaskes, Marian I. G.....210 E. Hillsdale St., Lansing
Cheney, Wm. D.....Sparrow Hosp., X-ray, Lansing
Chi, Seong H. (A).....Ingham Medical Hosp., Lansing
Cipparone, Joseph R.....St. Lawrence Hosp., Lansing
Clark, Gaius D.....Oldsmobile Div., GMC, Lansing
Clark, Wm. E. (A).....809 E. Ash St., Mason
Clinton, George R.....Rt. 2, Mason
Clore, Forrest C.....2909 E. Grand River, Lansing
Combs, Robt. G.....1023 E. Michigan Ave., Lansing 12
Comstock, Howard C.....2909 E. Grand River, Lansing 12
Cook, J. Maxwell.....3911 W. Michigan Ave., Lansing
Cope, Henry E. (R).....605 Westmoreland, Lansing 15
Cordes, Jerome F.....2909 E. Grand River, Lansing
Corneliuson, Goldie B.....Mich. Dept. of Health, Lansing 15
Cowan, John A.....825 Touraine, East Lansing
Cummings, Geo. D.....Mich. Dept. of Health, Lansing 4
Dale, Edward C.....Health Service MSU, East Lansing
Darling, Lewis H.....115 W. Hillsdale St., Lansing 15
Dawe, C. D.....1515 W. Mt. Hope Ave., Lansing
DeVries, Corydon F.....320 Townsend St., Lansing 15
Dexter, M. J.....229 E. Maple, Mason
Drolett, Alfred J. (L).....1018 Prudden Bldg., Lansing 16
Drolett, Donald J.....1322 E. Michigan Ave., Lansing 16
Drolett, Lawrence A.....3526 W. Saginaw St., Lansing 17
Dunkel, John F.....Edw. W. Sparrow Hosp., Lansing
Dunn, Forest M.....1322 E. Michigan Ave., Lansing
Ellis, Bertha W. (R).....Box 2327, Hollywood, Fla.
Ellis, C. Ward (L).....Box 2327 Hollywood, Fla.
Evans, Matthies.....1250 Haslett Rd., East Lansing
Feeney, Kenneth J.....1908 Mich Nat'l Tower, Lansing 15
Feurig, James S.....321 Kensington, East Lansing
Finch, Russell L. (L).....Morrison Lk. Gardens, Saranac
Folkers, Leonard M.....234 Michigan Ave., East Lansing
Fortino, Silvio P.....2909 E. Grand River, Lansing
French, Horace L.....1322 E. Michigan Ave., Lansing
Fryer, Douglas H.....Mich. Dept. of Health, Lansing 4
Gage, David P.....Vocational Rehabilitation, Box 1016, Lansing
Garlinghouse, A. John, Jr...1322 E. Michigan Ave., Lansing
Gellar, Abraham.....419 S. Walnut, Lansing
George, Harry C.....335 Seymour St., Lansing 33
Ghannam, Rasem (A).....2627 Patricia St., Ann Arbor
Ginnebaugh, L. A.....77 Rose St., Battle Creek
Govons, Sidney R.....1322 E. Michigan Ave., Lansing
Grey, Anna B.....219 Oakland Dr., East Lansing
Hames, R. E.....1322 E. Michigan Ave., Lansing
Hanna, Roger J.....117 E. Maple, Mason
Harrington, Louis E.....3526 W. Saginaw St., Lansing 17
Harris, Herbert W.....609 N. Washington Ave., Lansing 15
Harrison, Wm. H.....834 W. St. Joseph St., Lansing 15
Harrold, Jesse F.....326 W. Ionia, Lansing 33
Hatton, R. L.....4462 Greenwood St., Okemos
Hay, Kent R.....1322 E. Michigan Ave., Lansing
Hayes, Robt. E.....1322 E. Michigan Ave., Lansing 12
Hayford, Wm. D.....1028 E. Saginaw St., Lansing
Heald, Gordon H.....714 Abbott Road, East Lansing
Heckert, Frank B...1105 Bank of Lansing Bldg., Lansing 16
Heckert, Jos. K.....1105 Bank of Lansing Bldg., Lansing 16
Heerdt, Mark E.....810 W. Saginaw, Lansing
Henderson, Norman D.....1017 E. Grand River, E. Lansing
Henry, Robt. A. (A).....Ypsilanti State Hosp., Ypsilanti
Hermes, Edgar J.....604 W Willow St., Lansing
Heustis, Albert E.....Mich. Dept. Health, Lansing
Himmelberger, R. J.....3624 Colchester, Lansing 6
Hiscoe, D. Bonta.....2909 E. Grand River, Lansing
Hoffer, W. E. (L).....331 Shepard St., Lansing
Hogg, Raymond E.....2909 E. Grand River, Lansing

Holland, Chas. F.....810 W. Saginaw, Lansing
Horvath, Francis.....MSU Health Center, East Lansing
Howe, Gertrude E.....Mich. Dept. of Health, Lansing
Hoyt, John C.....2107 Aurelius Rd., Holt
Huggett, Clare C.....122 W. Gd. River Ave., Lansing
Hurth, M. S.....1717 Jerome St., Lansing
Imeson, Elizabeth W.....Mich. Dept. of Health, Lansing
Isbister, J. L.....Dept. Health, DeWitt Rd., Lansing
Iung, Omero S.....411 Bartlett, Lansing
Jacob, S. Sprigg, III.....201 Ann St., East Lansing
Jarstfer, Bruce S. (A).....U.S.A. Tripler Gen. Hosp., Honolulu, Hawaii
Johnson, David B.....2909 E. Grand River, Lansing
Johnson, Henry T. (N).....3501 W. VanBuren, Phoenix, Ariz.
Johnson, Kenneth H.....1116 Mich. Nat'l Tower, Lansing
Johnson, Richard.....2909 E. Grand River, Lansing
Jones, Francis A., Jr. (R).....815 Royal Palm Pl., Vero Beach, Fla.
Jones, Martin F.....2909 E. Grand River, Lansing
June, Robt. C.....209 N. Walnut, Lansing 33
Kahn, David.....2909 E. Grand River, Lansing
Kalmbach, Roland E.....1322 E. Michigan, Lansing
Katlein, Stanley (A).....St. Lawrence Hosp., Lansing
Kellerman, Howard H...1322 E. Michigan Ave., Lansing 12
Kelly, William.....Cass Bldg., Lansing
Kent, A. Edith Hall.....Box 1167, Lansing
Kent, Herbert K.....M.O. Box 1167, Lansing 13
Kinzel, Raymond C.....326 W. Ionia St., Lansing
Klunzinger, W. R.....326 W. Ionia St., Lansing 33
Kozak, Jerome S.....609 N. Washington Ave., Lansing
Kraft, Lester C.....209 S. Main St., Leslie
Lambert, Harold J.....Mich. Dept. of Health, Lansing
Lange, Philip F.....1923 S. Cedar St., Lansing 10
Lanting, Helen E. P.....600 Lesher Place, Lansing 15
Larkey, Paul E.....110 N. Rosemary St., Lansing
Larson, Homer I.....1322 E. Michigan Ave., Lansing 12
Lauzun, Virginia D.....1654 E. Grand River, East Lansing
LeDuc, Don M.....317 W. St. Joseph St., Lansing
Leshock, Jos. C.....2909 E. Grand River, Lansing
Levett, Harry L.....2909 E. Grand River Ave., Lansing
Lewis, Clayton, Jr.....2909 E. Grand River, Lansing
Linnell, Paul C. (A).....1724 Covington, Ann Arbor
Long, Chas. O., Jr.....2909 E. Grand River, Lansing
Loree, Maurice C.....120 W. Hillsdale St., Lansing 15
Loughrin, T. D.....335 Seymour, Lansing
Love, James M.....P.O. Box F, Okemos
Lucas, Thos. A.....1515 W Mt. Hope, Lansing
Ludlum, Lewis C.....1126 W. Saginaw St., Lansing 15
Malcolm, Henry E.....2909 E. Grand River, Lansing
Mannausa, L. R.....2909 E. Grand River Ave., Lansing
Marta, John B.....1322 E. Michigan Ave., Lansing
Martin, Wayne O.....4765 Nakoma Dr., Okemos
Marzolf, M. Finette (N).....3315 Wisconsin N.W., Washington 16, D. C.
Mavromatis, E.....1322 E. Michigan Ave., Lansing
Mavromatis, F.....1322 E. Michigan Ave., Lansing
May, Stephen G.....202 M.A.C. Ave., East Lansing
McCorvie, C. Ray.....903 E. Grand River Ave., E. Lansing
McCorvie, Donald R.....Williamston Med. Bldg., Williamston
McElmurry, Leland R.....209 N. Walnut St., Lansing 15
McFarlane, Donald R.....1322 E. Michigan Ave., Lansing 12
McGillicuddy, O. B.....1816 Mich. Nat'l Tower, Lansing
McGillicuddy, R. J.....300 W. Ottawa St., Lansing 15
McKenney, Marvin J.....1322 E. Michigan Ave., Lansing
Meade, Wm. H.....1023 E. Michigan, Lansing
Meinke, Richard K.....1322 E. Michigan Ave., Lansing
Melick, Richard C.....326 W. Ionia, Lansing 33
Mercer, Walter E. (R).....909 Glenhaven, East Lansing
Messenger, A. L.....1322 E. Michigan Ave., Lansing
Miller, J. Thomas.....790 E. Columbia, Mason
Miller, Willard J.....930 N. Washington, Lansing
Monfort, Robt. N. (R).....300 Pacific Rd., Miami, Fla.
Moore, Charles R.....1322 E. Michigan Ave., Lansing
Moore, Donald B.....1322 E. Michigan Ave., Lansing 12
Morrow, Robt. J.....412 N. Capitol, Lansing
Nadeau, John H. (M).....24679 Rosalind St., East Detroit
Nakfoor, Eugene C.....2909 E. Grand River, Lansing
Neering, James C.....1322 E. Michigan Ave., Lansing 12
Neuman, John R.....3911 W. Michigan Ave., Lansing
Newitt, A. W.....221 W. Washtenaw, Lansing
Nicholas, Mildred V.....5596 Portage Lake Rd., Dexter
Niland, Paul T.....1322 E. Michigan Ave., Lansing 12
Nobel, Rudolf E. (A).....1577 Andrea, Ypsilanti
Ochsner, Paul J.....Fisher Body Corp., Lansing 4
Packer, John H.....2909 E. Grand River, Lansing
Palmer, R. E. (L).....535 S. Capitol Ave., Lansing
Parker, Earl E.....207 E. Bellevue, Leslie
Payne, Thomas C.....2909 E. Grand River Ave., Lansing
Peets, Ronald.....Gr. River & Grandview, Okemos
Philips, David P.....1217 Loraine Ave., Lansing 10
Plant, John F.....2909 E. Grand River, Lansing
Plesscher, Wm. H.....1322 E. Michigan Ave., Lansing
Pomeroy, Richard W.....1322 E. Michigan Ave., Lansing
Powell, Gerald D.....1515 W. Mt Hope Ave., Lansing
Prall, Harry J.....214 W. Main St., Lansing 33
Pung, Elba Molina.....1512 E. Michigan, Lansing 12
Randall, O. M. (R).....7557 W. Saginaw, R.R. 1, Lansing
Rector, Frank L. (R).....2835 N.E. Brazee Court, Portland 12, Ore.
Reid, Harold E.....359 University Dr., East Lansing
Reynolds, Edward E.....Rt. 2, Box B, Williamston
Rice, R. G.....252 Hollister Bldg., Lansing
Richards, Frank D.....1322 E. Michigan Ave., Lansing
Richardson, Maurice L.....1215 E. Michigan Ave., Lansing 12
Robson, Edmund J.....215 N. Walnut St., Lansing 15
Rollstin, Robt. A.....1014 Townsend St., Lansing 21
Rozan, Josef S.....2909 E. Grand River, Lansing
Ruhmkorff, Ralph H.....MSU Health Center, East Lansing
Rutledge, Saml. H., Jr...1322 E. Michigan Ave., Lansing 12
Saenz, Hugo R.....1515 W Mt. Hope, Lansing
Saker, James H.....201 W. Hillsdale St., Lansing
Sander, John F.....4780 Okemos Rd., Okemos
Saunders, M. R. (A).....2601 N. Whittier, St. Louis, Mo.
Sawvell, Austin R.....810 W. Saginaw St., Lansing
Scallin, J. F.....810 W. Saginaw, Lansing
Schaffer, Carole S. (A)....843 Lantern Hill Dr., E. Lansing
Scheidt, R. Rudolph.....1133 Seymour Ave., Lansing
Schmidt, Harry J.....2909 E. Grand River, Lansing
Schultz, Arthur E.....4646 Ottowa Dr., Okemos
Seger, Fred L. (L).....1035 Cherry St. N.E., St. Petersburg 4, Fla.
Shapiro, Hyman D.....201 W. Hillsdale St., Lansing
Sharp, Mahlon S.....521 N. Capitol, Lansing
Shaw, Milton.....320 Townsend St., Lansing 15
Sheehan, F. Michael.....233 Leland Place, Lansing 17
Sheets, Joseph L.....521 N. Capitol Ave., Lansing
Sherman, Geo. A.....112 W. Hillsdale, Lansing 15
Sichler, Harper G. (R).....301 Seymour Ave., Lansing 15
Siegel, David.....2909 E. Grand River, Lansing
Silverman, Irving E.....2909 E. Grand River, Lansing
Sleight, Justin L.....2909 E. Grand River, Lansing
Smith, Anthony V.....116 W. Sycamore, Mason
Smookler, Bernard H.....2909 E. Grand River, Lansing
Snyder, LeMoyne.....P.O. Box S, Paradise, Calif.
Snyder, Ruth C. E.....234 W. Michigan Ave., East Lansing
Spagnuolo, Alfred J.....1418 S. Logan St., Lansing
Spencer, J. Clyde.....Sparrow Hospital, Lansing
Spencer, Perry C.....320 Townsend St., Lansing 15
Stanley, Arthur L.....1322 E. Michigan Ave., Lansing
Stehman, Vernon A.....Lewis Cass Bldg., Lansing
Steinem, David L.....Lansing Mental Health Ctr., Lansing
Steiner, Abraham A. (R).....Route 3, Grand Ledge
Stephan, Winton E.....1322 E. Michigan Ave., Lansing
Stilwill, Geo. D.....2909 E Grand River, Lansing
Stimson, Paul R.....119 E. Grand River, East Lansing
Stone, Benj. J.....2909 E. Grand River, Lansing
Stow, Robt. M.....2909 E. Grand River, Lansing
Strauss, Percival C.....3813 W. Willow, Lansing
Strempek, Walter F.....726 Whitehills Dr., East Lansing
Stringer, C. J.....1322 E. Michigan Ave., Lansing
Sundell, Edwin C.....1028 E. Saginaw, Lansing
Swartz, Fredk. C.....720 Seymour St., Lansing
Tamblyn, Fredk. W.....335 Seymour Ave., Lansing 33
Thaden, D. W.....208 M.A.C. Ave., East Lansing
Thimmig, Robt. F.....1322 E. Michigan Ave., Lansing 12
Tien, Hsin, Chen.....124 W. Grand River Ave., E. Lansing
Toothaker, Kenneth W.....930 N. Washington Ave., Lansing
Trager, Fredk. C.....1322 E. Michigan Ave., Lansing 12
Trescott, Robt. F.....1322 E. Michigan Ave., Lansing
Trimby, Robt. H.....1322 E. Michigan Ave., Lansing

Troost, Franklin L.....4378 W. Delhi Rd., Holt
Tucker, Billy J.....809 E. Kingsley, Ann Arbor
Urban, Eva.....540 Glenmoor, East Lansing
Vanderzalm, T. P.....1452 Cambridge Rd., Lansing
Venier, Jos. H.....544 Division, East Lansing
Wadley, Ralph.....335 Seymour Ave., Lansing 33
Walker, Leo W.....4225 Apple Tree Lane, Lansing
Warren, Leon H.....3500 N. Logan St., Lansing
Wasty, George (A).....Henry Ford Hospital, Detroit
Wellman, John M.....1322 E. Michigan Ave., Lansing
West, Chas. Carl.....2909 E. Grand River, Lansing
Wilcox, K. R., Jr.....Mich. Dept. of Health, Lansing
Wilensky, Thos.....201 W. Hillsdale, Lansing
Willson, Howard S.....704 Mich. Nat'l Tower, Lansing 8
Worthington, Ralph.....810 W. Saginaw, Lansing 15
Wortley, Chas K.....1017 E. Grand River, East Lansing
Zick, Gerald A.....1322 E. Michigan Ave., Lansing 12
Ziel, Hermann A., Jr.....Mich. Dept. of Health, Lansing

IONIA-MONTCALM COUNTY MEDICAL SOCIETY (94)

Anderson, D. Hess.....207 Bridge St., Portland
Bennett, W. Bruce.....Lakeview Hospital, Lakeview
Bird, Wm. L.....917 W Oak St., Greenville
Birzgalis, Alfreds A.....Ionia State Hospital, Ionia
Buck, Jack H.....517 Division, Ionia
Bunce, Leo W.....Trufant
Campbell, Richard E.....106 N. Depot, Ionia
Dunkin, Lloyd S.....410 S. Clay St., Greenville
Foust, Jos. C. (A).....Kisa Box 73, Tukuyu, Tanganyika, E. Africa
Fox, Harold M.....Portland
Geib, Oscar P. (L).....Gaylord
Halick, John.....200 S. Franklin, Greenville
Hansen, Carl M.....Stanton
Haskell, Robt. H. (L).....Zetlands Estate Twr., Nevis, Leeward Isl., B.W.I.
Hoffs, Marinus A.....911 Fourth St., Lake Odessa
House, Glenn W., Jr.....1200 W Oak St., Greenville
Kazmers, Nikolas.....Lakeview
Kopchick, Jos.....Muir
Kozachik, Martin J.....123 Bridge St., Portland
Lilly, Isaac S. (L).....Stanton
London, John L.....Lakeview
Marston, Leo L.....Box 235, Lakeview
Merchun, Frank A.....11804 W. Carson City Rd., Greenville
Mitchell, Harold C.....509 Johnson St., Ionia
Naglins, Jekabs.....Ionia State Hospital, Ionia
Olsen, Bruce C.....917 W. Oak St., Greenville
O'Malley, R. J.....230½ W. Main, Ionia
Rice, Robt. E.....P.O. Box 271, Greenville
Robertson, Perry C. (L).....327 Center St., Ionia
Sanford, Louis E.....219 Main St., Belding
Slagh, Milton E.....Saranac
Smith, Robt. O.....724 Roselawn, Ionia
Socha, Edmund S.....217 E. Main, Ionia
Stevens, Charles E.....513 N. Lafayette St., Greenville
Tannheimer, John F.....525 Lafayette St., Ionia
Van Loo, Jacob.....103 E. Washington, Belding
Younis, Ahmad.....821 Macomber St., Greenville

JACKSON COUNTY MEDICAL SOCIETY (98)

Adams, Ellis W.....517 Wildwood Ave., Jackson
Ahronheim, J. H.....Foote Memorial Hospital, Jackson
Allen, Duane M.....Hanover Medical Center, Hanover
Appel, Saul.....112 W. Michigan Ave., Jackson
Baker, Geo. M.....350 S. Union, Parma
Beckwith, Sidney A.....100 E. Main St., Stockbridge
Bentley, Jack P.....2532 Spring Arbor Rd., Jackson
Bentley, Mary E. N.....2532 Spring Arbor Rd., Jackson
Brashares, Zane A.....Brooklyn
Bullen, G. R.....418 Third St., Jackson
Buslepp, Robert C.....901 Reynolds Bldg., Jackson
Clarke, Corwin S. (L).....Hacinda Carmel, Carmel, Calif.
Cooley, Chas. W.....Mercy Hospital, Jackson
Cooley, Randall M. (L).....141 E. Robinson St., Jackson
Corley, Cecil (L).....204 Homecrest Rd., Jackson
Corley, Ennis H.....1401 Reynolds Bldg., Jackson
Corley, Robt. W.....204 Homecrest Rd., Jackson
Cox, Ferdinand (L).....1601 4th St., Jackson
Culver, Raymond E.....435 Wildwood Ave., Jackson
Daly, Byrne M.....297 W. Michigan, Jackson
Davenport, Bruce.....404 McNeal St., Jackson
DeMay Cuthbert E. (L).....403 E. Michigan Ave., Jackson
DeMay, John D.....403 E. Michigan Ave., Jackson
Deming, Richard C.....724 W. Franklin, Jackson
Dengler, Chas. R. (L).....504 3rd St., Jackson
Douglas, Edward W. (L).....468 4th Avenue, New Kensington, Pa.
Filip, Hypolit K., Jr.....P.O. Box 84, Jackson
Finton, Robt. E.....610 W. Michigan, Jackson
Greenbaum, Harry.....1203 Greenwood Ave., Jackson
Growt, Bowers H. (L).....Addison
Habenicht, Hilda A.....545 Lansing Ave., Jackson
Hackett, Thos. L.....519 N. East Ave., Jackson
Hamilton, James G.....610 N. West Ave., Jackson
Hanft, Cyril F.....144 E. Main St., Springport
Hardie, Geo. C.....724 W. Michigan, Jackson
Hicks, Glenn C. (L).....1009 Wildwood Ave., Jackson
Holst, John B.....606 City Bank Bldg., Jackson
Joerin, Wm. A.....612 First St., Jackson
Karr, Jean P.....502 W. Michigan Ave., Jackson
Keefer, Albert H.....Concord
Kempton, Geo. B.....511 S. West Ave., Jackson
Kiessling, A. J., Jr.....511 S. West Ave., Jackson
Kobs, Robt. J.....608 W. Michigan Ave., Jackson
Kudner, Donald F.....435 Wildwood Ave., Jackson
Lake, Edward C.....612 1st St., Jackson
Landron, Danl.....4633 Page, Michigan Center
Latchaw, William R.....4000 Cooper St., Jackson
Lenz, Chas. R., Jr.....405 1st St., Jackson
Lewis, Elmore F. (L).....1112 Carlton Blvd., Jackson
Linden, Victor E.....2025 Fourth St., Jackson
Maas, Gerald I.....1615 Carlton Blvd., Jackson
McGarvey, Wm. E. (L).....161 W. Michigan Ave., Jackson
McLaughlin, John M.....710 S Brown St., Jackson
McLaughlin, Miar J. (L).....710 S Brown St., Jackson
McLauthlin, H. B.....439 Wildwood Ave., Jackson
McQuillan, F. P.....611 Center St., Jackson
Meads, Jason B.....161 W. Michigan Ave., Jackson
Medlar, Robt. E.....719 Seventeenth St., Jackson
Morelli, Lorenzo.....401 W. Prospect St., Jackson
Muhich, Ralph A.....2532 Spring Arbor Rd., Jackson
Munro, Colin D. (L).....740 W. Michigan, Jackson
Munro, Nathan D.....740 W. Michigan Ave., Jackson
Murphy, Bernard M.....1134 E. Ganson St., Jackson
Newton, Ray E. (L).....180 W. Michigan Ave., Jackson
Niekamp, Harold.....2532 Spring Arbor Rd., Jackson
Oleksy, Stanley P.....744 W. Michigan, Jackson
Olsen, Lloyd L.....610 W. Michigan Ave., Jackson
Oster, Harold L.....1218 Greenwood Ave., Jackson
Otis, Grant L.....525 Wildwood Ave., Jackson
Payne, Andrew K.....Foote Memorial Hospital, Jackson
Phillips, Geo. H.....Jackson Co. TB Sanat., Jackson
Pray, Frank F. (L).....310 Steward Ave., Jackson
Pray, Geo. R. (L).....404 S. Jackson St., Jackson
Preston, Joseph A.....Mercy Hospital, Jackson
Rice, John W.....421 McNeal St., Jackson
Ries, Richard G.....612 First St., Jackson
Riley, Philip A.....500 S. Jackson St., Jackson
Riley, Philip A., Jr.....500 S. Jackson St., Jackson
Rua, Ignacio.....1810 W. High, Jackson
Rucker, Joseph.....1012 Francis St., Jackson
Sargent, Leland E.....Foote Memorial Hospital, Jackson
Sautter, Wm. A.....Horton
Schmidt, Theophile E. (L)..180 W. Michigan Ave., Jackson
Schneider, R. H.....724 W. Franklin, Jackson
Scott, John A., Jr.....432 W. Michigan, Jackson
Schaeffer, Leland D.....1615 Carlton Blvd., Jackson
Sher, David B. (R).....3800 Kirkwood, Jackson
Sill, Henry W.....724 W. Michigan Ave., Jackson
Sirhal, Alfred M.....Brooklyn

Smith, Dean W.....500 W. Michigan Ave., Jackson
Southwick, W. A.....130 Maple Street, Springport
Stackable, Wm. R.....2532 Spring Arbor Rd., Jackson
Stewart, Lewis L., Jr.....1919 Kibby Rd., Jackson
Stolberg, Carl A.....724 W. Franklin, Jackson
Stone, Ethon L.....721 Seventeenth St., Jackson
Sugar, Saml.....180 W. Michigan Ave., Jackson
Tate, Cecil E.....1315 Francis St., Jackson
Taylor, Ross V.....517 Wildwood Ave., Jackson
Thalner, Leonard F.....609 W. Michigan Ave., Jackson
Thayer, Earl A. (L).....120 W. Michigan Ave., Jackson
Thompson, T. B.....434 Wildwood Ave., Jackson
Townsend, James W. (L).....108 Hauge Ave., Vandercook Lake, Jackson
Van Schoick, Frank.....419 W. High St., Jackson
Van Schoick, John D. (L).....Hanover
Van Schoick, R. M.....2120 Cascade Drive, Jackson
Van Wagnen, F. I., Jr.....434 Wildwood Ave., Jackson
Vivirski, Edward E.....603 S. Elm Ave., Jackson
Weddon, Edward R.....R.F.D. 2, Stockbridge
Wholihan, John W.....604 W. Michigan Ave., Jackson
Wickham, Woodward A.....2029 Fourth, Jackson
Wille, Warren S.....1204 First St., Jackson

KALAMAZOO ACADEMY OF MEDICINE (102)

Aach, Hugo A.....3314 Bronson Blvd., Kalamazoo 37
Ajemian, Edward P.....252 E. Lovell St., Kalamazoo
Alexander, C. A.....118 W. North St., Kalamazoo
Andrews, Sherman E.....224 E. Cedar St., Kalamazoo 8
Andrews, Thomas E.....224 E. Cedar St., Kalamazoo
Angell, Howard H. (A).....301 Henrietta St., Kalamazoo
Anglin, Walter M.....7211 Lantollarrey Rd., Kalamazoo
Appel, Ben A.....252 E. Lovell St., Kalamazoo
Appell, Wm. P.....252 E. Lovell St., Kalamazoo 8
Appell, Lloyd E.....126 N. Kalamazoo Ave., Vicksburg
Armstrong, Robt. J.....103 N. Burdick St., Kalamazoo 1
Balian, John V.....501 Bronson Med. Cen., Kalamazoo
Banner, Lawrence R.....Borgess Med. Center, Kalamazoo
Barrows, Winona M.....1500 Blakslee St., Kalamazoo
Barry, Manley L.....Plainwell Sanit., Plainwell
Bateman, William T.....914 S. Burdick, Kalamazoo
Bennett, Keith F.....252 E. Lovell St., Kalamazoo
Berglund, Thomas R.....6646 Portage Rd., Kalamazoo
Berglund, V. A.....6646 Portage Rd., Kalamazoo
Berry, Ivor, Jr.....516 Whites Rd., Kalamazoo
Betz, Eldean G.....1711 Merrill, Kalamazoo 6
Birch, Wm. G.....252 E. Lovell St., Kalamazoo 5
Bodmer, Harvey C.....403 W. Kalamazoo Ave., Kalamazoo
Bond, Glenn C. (A).....2824 S. Burdick St., Kalamazoo
Breneman, James C.....25 Pearl St., Galesburg
Brooks, Bert W.....4340 Lakeside Dr., Kalamazoo
Brown, Irmel W.....107 W. Michigan Ave., Kalamazoo
Brue, Peter P.....1009 Cambridge Dr., Kalamazoo
Burdick, Harry W.....1223 S. Park St., Kalamazoo
Burrell, Robt. B.....1711 Merrill St., Kalamazoo
Butler, Wm. J.....1631 Gull Rd., Kalamazoo
Callander, C. Glen.....252 E. Lovell St., Kalamazoo
Carter, E. R.....1324 S. Park St., Kalamazoo
Cartland, Geo. F., Ph.D. (A).....1704 Dover Rd., Kalamazoo
Cashen, Russell M.....252 E. Lovell St., Kalamazoo
Chodos, Dale D. J. (A).....301 Henrietta St., Kalamazoo
Chrest, Clarence P.....458 W. South St., Kalamazoo
Clement, F. L.....502 Bronson Med. Cen., Kalamazoo
Conrad, Maynard M.....252 E. Lovell St., Kalamazoo
Cooper, Paul F.....252 E. Lovell St., Kalamazoo
Cornish, F. L., III.....1631 Gull Rd., Kalamazoo
Cox, Franklin.....Borgess Hospital, Kalamazoo
Crawford, Kenneth L.....612 Douglas, Kalamazoo
Crawley, Kenneth R. (A).....301 Henrietta St., Kalamazoo
Creager, Ray O.....1218 Bronson Circle, Kalamazoo
Cretsinger, Francis C.....224 E. Cedar St., Kalamazoo
Currier, Richard K.....6646 Portage Rd., Kalamazoo
Dahlstrom, Doris E.....723 S. Westnedge Ave., Kalamazoo
Damiano, Robert E.....301 Henrietta St., Kalamazoo
Dana, Robt. L.....1631 Gull Rd., Kalamazoo
Decker, Wm. A.....1207 Oakland, Kalamazoo
Delbert, Stewart G.....914 S. Burdick St., Kalamazoo
DeLong, Robt. E.....Borgess Med. Center, Kalamazoo
DePree, Harold E.....252 E. Lovell St., Kalamazoo
DeVries, John M.....516 Whites Rd., Kalamazoo
Dew, Robt. R.....1711 Merrill St., Kalamazoo
DeWitt, Norman L.....103 N. Burdick St., Kalamazoo
Dick, Leo A.....611 Howard St., Kalamazoo
Doezema, Edward R.....516 Whites Rd., Kalamazoo
Dowd, Bennard J.....1700 Gull Rd., Kalamazoo
Doyle, Fredk. M.....611 Howard St., Kalamazoo
Dugger, James A.....2901 S. Westnedge Ave., Kalamazoo
Endrei, Arisztid.....1312 Oakland Dr., Kalamazoo
Estill, Don V.....414 W. Patterson St., Kalamazoo
Fath, August F.....1711 Merrill, Kalamazoo
Ferguson, Robt. K.....1324 S. Park, Kalamazoo
Finton, Max A.....252 E. Lovell St., Kalamazoo
Flunt, Roman.....Box A, Kalamazoo St. Hosp., Kalamazoo
Fopeano, John V.....1711 Merrill St., Kalamazoo
Fosmoe, Robert J.....458 W. South St., Kalamazoo
Fry, J. William.....212 Bronson Med Center, Kalamazoo
Fuller, Paul M.....1700 Gull Rd., Kalamazoo
Gardner, Carl A.....1410 Amer. Nat'l Bank, Kalamazoo
Gerard, Earl S. (A).....3410 Runnymede Dr., Kalamazoo
Gerstner, Richard M.....212 Bronson Med. Ctr., Kalamazoo
Gibson, Richard E.....Schoolcraft
Gladstone, Wm. S.....458 W. South St., Kalamazoo
Glaser, Danl. F.....463 Academy St., Kalamazoo
Goodhue, Lolita G. (L).....2503 W. Main St., Kalamazoo
Gove, Robert S.....1631 Gull Rd., Kalamazoo
Graf, Michael.....1631 Gull Rd., Kalamazoo
Grekin, Robt. H.....136 E. Michigan Ave., Kalamazoo
Gremel, Norman.....458 W. South St., Kalamazoo
Haddock, D. A., Jr.....6646 Portage St., Kalamazoo
Hagans, James A.....301 Henrietta St., Kalamazoo
Hailman, Harold F.....P.O. Box 130, Yonkers, N. Y.
Hammer, John M.....100 Maple St., Parchment
Hanson, Curtis M.....252 E. Lovell St., Kalamazoo
Hare, J. Donald.....516 Whites Road, Kalamazoo
Harrell, Frank G.....1602 Gull Rd., Kalamazoo
Harrelson, Wm. D.....1324 S. Park, Kalamazoo
Hayner, Russell A.....4015 Portage, Kalamazoo
Heersma, H. Sidney.....1711 Merrill St., Kalamazoo
Heinle, Robt. W.....Med. Div., Upjohn Co., Kalamazoo
Hendrix, J. W. (A).....2430 Wildemere St., Kalamazoo
Hersey, E. Freeman.....1215 Oakland Drive, Kalamazoo
Hersey, Margaret S.....1215 Oakland Dr., Kalamazoo
Hildreth, Roscoe C.....458 W. South St., Kalamazoo
Hodgman, Albert B.....612 Douglas Ave., Kalamazoo
Hodgman, Richard W.....612 Douglas Ave., Kalamazoo
Hoekstra, George J.....100 Maple St., Parchment
Howard, Willard H.....1536 Gull Rd., Kalamazoo
Hubbard, Edwin M.....252 E. Lovell St., Kalamazoo
Hume, Robt. H.....1711 Merrill St., Kalamazoo
Hunt, Jack.....1631 Gull Rd., Kalamazoo
Huyser, Wm. C. (L).....427 S. Burdick St., Kalamazoo
Irwin, Wm. D.....103 N. Burdick St., Kalamazoo
Janke, Robert A.....1416 W. Milham Rd., Kalamazoo
Jennings, Robt. M.....Box A, Kalamazoo State Hosp., Kalamazoo
Johnson, Fenimore T. (A).....Med. Div. Upjohn Co., Kalamazoo
Kavanaugh, John.....1631 Gull Rd., Kalamazoo
Kavanaugh, T. E.....1631 Gull Rd., Kalamazoo
Kavanaugh, Wm. R.....612 Douglas Ave., Kalamazoo
Kercher, Ervin F.....216 Bronson Med. Ctr., Kalamazoo
Kettunen, Robert C.....252 E. Lovell St., Kalamazoo
Kihm, John L.....1223 S. Park St., Kalamazoo
Kilgore, Robt. N.....252 E. Lovell St., Kalamazoo
Kincaid, Joseph E.....420 John St., Kalamazoo
Klerk, Wm. J.....914 S. Burdick St., Kalamazoo
Koestner, Paul A.....1303 Portage St., Kalamazoo
Lavender, Howard C. (A).....136 E. Michigan Ave., Kalamazoo
Lawrence, James O.....1409 Henderson Dr., Kalamazoo
Lawson, James B. (A).....Rt. 1, Box 190, Vicksburg
Lemmer, Richard A.....252 E. Lovell St., Kalamazoo
Light, Richard U.....916 American Natl. Bk. Bldg., Kalamazoo
Littig, John D.....1324 S. Park St., Kalamazoo
Locklin, W. Kaye.....136 E. Michigan, Kalamazoo
Louisell, James M.....611 Whitcomb St., Kalamazoo

Lowe, W. Carter.....252 E. Lovell St., Kalamazoo
Loynd, James W., II.....1324 S. Park St., Kalamazoo
MacDonald, M. A.....252 E. Lovell St., Kalamazoo
MacGregor, John R.....100 Maple St., Parchment
Machin, Harold A.....420 John St., Kalamazoo
MacLeod, Garrard A., Ph.D., (A).....Upjohn Company Kalamazoo
Malone, James G.....420 John St., Kalamazoo
Margolis, Fredk. J.....2901 S. Westnedge, Kalamazoo
Marshall, Don.....252 E. Lovell St., Kalamazoo
Marshall, Evelyn M. W. (A).....1508 Timberlane Dr., Kalamazoo
Marshall, Wm. P.....705 Hanselman Bldg., Kalamazoo
Martens, Irvin J.....1521 Gull Rd., Kalamazoo
May, Donald G.....516 Whites Rd., Kalamazoo
McCarthy, Jos. S. (L).....1521 Gull Lake Rd., Kalamazoo
McColl, John A.....1631 Gull Rd., Kalamazoo
McMahon, F. Gilbert.....4302 Edgecliff Lane, Kalamazoo
Mellis, Richard.....611 Whitcomb St., Kalamazoo
Moe, Carl R.....1324 S. Park St., Kalamazoo
Molony, Basil A.....3603 Runnymede Dr., Kalamazoo
Morter, Roy A. (L).....2421 Sheffield, Kalamazoo
Murdy, Robert C...Box A, Kalamazoo St. Hosp., Kalamazoo
Neerken, Adrian J.....404 Bronson Med. Ctr., Kalamazoo
Nicholson, Robt. M.....1711 Merrill, Kalamazoo
O'Donovan, C. J.....2308 Broadmoor Dr., Elkhart, Ind.
Overbey, Chas. B., Jr.....1000 Oakland Dr., Kalamazoo
Patmos, Martin.....252 E. Lovell St., Kalamazoo
Peake, Chas. O., III.....252 E. Lovell St., Kalamazoo
Pearson, Edwin O.....458 W. South St., Kalamazoo
Peelen, J. W.....611 Whitcomb St., Kalamazoo
Peelen, Matthew.....252 E. Lovell St., Kalamazoo
Peltier, Hubert C. (A)....The Upjohn Company, Kalamazoo
Perry, Clifton W.....1711 Merrill St., Kalamazoo
Pinkham, Raymond A.....611 Whitcomb St., Kalamazoo
Pool, John D.....1711 Merrill St., Kalamazoo
Powley, Gerald W.....1711 Merrill St., Kalamazoo
Pullon, Alton E.....1223 S. Park St., Kalamazoo
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Sofen, Morris B.....107 W. Michigan Ave., Kalamazoo
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Beeman, Carl B.....515 Lakeside Dr. S.E., Grand Rapids 6
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Bell, Chas. M.....50 College Ave. S.E., Grand Rapids 3
Benisek, George J.....322 Lakewood Dr. S.E., Grand Rapids 6
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Davis, Roy A.....4236 Kalamazoo Ave. S.E., Grand Rapids 8
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Fochtman, Thos. W.....72 E. Division, Sparta
Foshee, J. Clinton.....124 Fulton St. E., Grand Rapids 2
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Fricke, David W. (A)....245 Cherry St. S.E., Grand Rapids
Fuller, Edson H., Jr.....74 Ionia Ave. N.W., Grand Rapids 2
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Fuller, Wm. J.....515 Lakeside Dr. S.E., Grand Rapids 6

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Gibbs, Floyd F.....4338 Division Ave. S., Grand Rapids 8
Gilbert, Ralph H.....26 Sheldon Ave. S.E., Grand Rapids
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Grass, Edward J.....833 Lake Dr. S.E., Grand Rapids 6
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Heetderks, Dewey R.....245 State St. S.E., Grand Rapids 2
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Schnute, Louise F.....146 Monroe N.W., Grand Rapids 2
Schwaderer, Thos. G. (A).....(Address Unknown)
Scott, Wm. B.....26 Sheldon Ave. S.E., Grand Rapids 2
Sculley, Raymond E.....12 Burton St. S.E., Grand Rapids
Seime, Reuben I.....201 Lafayette S.E., Grand Rapids
Sevensma, Elisha S. (L)..1077 Leonard N.E., Grand Rapids
Sevensma, Eugene S.....1077 Leonard N.E., Grand Rapids
Sharda, Martin.....2435 Eastern Ave. S.E., Grand Rapids
Sharp, Robert B.....833 Lake Dr. S.E., Grand Rapids 6
Sidell, Richard H.....515 Lakeside Dr. S.E., Grand Rapids 6
Siebers, Bernard H.....1085 Leonard N.E., Grand Rapids
Sikkema, Donald E. (A).....6674 Clyde Park Ave., Grand Rapids
Sluyter, John S.....2740 Eastern S.E., Grand Rapids 7
Smith, Dean B.....50 College Ave. S.E., Grand Rapids
Smith, John H.....1840 Wealthy St. S.E., Grand Rapids 6
Smith, Robt. B.....26 Sheldon Ave. S.E., Grand Rapids 2
Smith, R. Earle (L)..74 Ionia Ave. N.W., Grand Rapids 2
Snider, John D.....1827 Argentina Dr. S.E., Grand Rapids
Snyder, Clarence A.....445 Cherry St. S.E., Grand Rapids
Snyder, Clarence H...500 Cherry St. S.E., Grand Rapids 3
Southwick, C. H.....515 Lakeside Dr. S.E., Grand Rapids 6
Southwick, G. Howard.....515 Lakeside S.E., Grand Rapids
Sprague, Wm. E.....1039 Fulton St. W., Grand Rapids 4
Starr, Charles R.....26 Sheldon Ave. S.E., Grand Rapids 2
Steffensen, W. H.....1810 Wealthy St. S.E., Grand Rapids
Stonehouse, Garnet G (R).....408 Medical Arts Bldg., Grand Rapids 2
Stoneman, Fernley.....3011 Wilson, Grandville
Stover, Virgil E.....860 Gladstone S.E., Grand Rapids 6
Strong, LeRoy E.....515 Lakeside Dr. S.E., Grand Rapids 6
Stuart, Gerhardus J. (L).....1140 Keystone Ave., River Forest, Ill.
Sugg, Cullen E.....303 Fulton St. E., Grand Rapids 3
Sugiyama, Tetsuo.....110 E. Fulton St.....Grand Rapids 2
Sun, Keh Ming.....St. Mary's Hosp. Lab., Grand Rapids 3
Sus Strong, Carl A. (R).....2335 Northview S.W., Grand Rapids
Swan, Jerome W.....26 Sheldon Ave. S.E., Grand Rapids 2
Swanson, Alfred B.....1810 Wealthy St. S.E., Grand Rapids 6
Swenson, Harold C.....124 Fulton St. E., Grand Rapids 2

Telego, A. J.....2505 Fletcher Dr. N.E., Grand Rapids 6
Ten Have, John....3515 Briggs Blvd. N.E., Grand Rapids 2
Ter Keurst, Donald H.....2402 Eastern Ave. S.E., Grand Rapids 7
Tesseine, Arthur J.....1328 Madison S.E., Grand Rapids 7
Teusink, James H.....Cedar Springs
Theodore, Paul G.....1520 Plainfield Ave. N.E., Grand Rapids 5
Thompson, Athol B.....1810 Wealthy St. S.E., Grand Rapids 6
Thompson, Edward C.....153 Lafayette Ave. S.E., Grand Rapids 3
Thompson, Frank D.....4011 Reeds Lk. Blvd. S.E., Grand Rapids 6
Tidey, Marcus B. (A)..7157 Wildermere Dr. N.E., Rockford
Tiffany, Jos. C.....2322 Jefferson Dr. S.E., Grand Rapids 7
Torgerson, Wm. R...Ramona Medical Center, Grand Rapids
Townsend, Jack H., 515 Lakeside Dr. S.E., Grand Rapids 6
Troske, Robt. L. (M)..250 Fuller St. S.E., Grand Rapids 6
Truog, Clarence P.....110 Fulton St. E., Grand Rapids 2
Turcotte, V. J., Jr...515 Lakeside Dr. S.E., Grand Rapids 6

Vaandrager, Vernon D. (A).....347 Bostwick Ave. N.E., Grand Rapids
Valdmanis, Ferdinands..2120 Lake Dr. S.E., Grand Rapids
Van Bree, Raymond S...812 Rosalie N.W., Grand Rapids 4
Van Dam, Forrest R...515 Lakeside Dr. S.E., Grand Rapids
Vanden Berg, A. R.....833 Lake Dr. S.E., Grand Rapids 6
Vanden Berg, Henry J. (L).....2933 Bonnell Road S.E., Grand Rapids
Vanden Berg, Wm. O.....50 College Ave. S.E., Grand Rapids 3
Vander Kolk, K. J.....2740 Eastern Ave. S.E., Grand Rapids 7
Vander Meer, Raymond.....26 Sheldon Ave. S.E., Grand Rapids 2
Vandermolen, John.....124 Fulton St. E., Grand Rapids 2
Vander Ploeg, R. A.....26 Sheldon Ave. S.E., Grand Rapids
Vander Ploeg, Wm. H., 833 Lake Dr. S.E., Grand Rapids 6
Van Der Veer, Corwin G.....245 State St. S.E., Grand Rapids 3
Van Dommelen, G. M.....456 Cherry St. S.E., Grand Rapids 3
Van Duine, Henry J.....153 Lafayette S.E., Grand Rapids 3
Van Dyke, Harold E...1108 Leonard St. N.E., Grand Rapids
Van Etten, Donald D. (A).....220 Union Ave. N.E., Grand Rapids 3
Van Goor, Kornelius.....26 Sheldon Ave. S.E., Grand Rapids 2
Van Noord, Gelmer A.....6850 Division Ave. S., Grand Rapids 8
Van Portfliet, Paul.....245 State St. S.E., Grand Rapids 3
Vansolkema, Andrew A.....953 E. Fulton St., Grand Rapids
Van T'Hof, Albert.....50 College Ave. S.E., Grand Rapids 3
Van Vliet, Peter D. (A).....1416 Berkman Ct. S.W., Rochester, Minn.
Van Woerkom, Danl.....933 Leonard St. N.W., Grand Rapids 4
Van Zanten Kuiper, K.....2208 Madison Ave. S. E., Grand Rapids
Van Zwalenburg, B. R.....2054 Anderson Dr. S.E., Grand Rapids 6
Vasu, C. Mark (A).....465 Tuttle N.E., Grand Rapids
Veldman, Harold E.....26 Sheldon Ave., Grand Rapids 2
Veltman, Jay H.....3946 G 30th St., Grandville
Venema, Jay R., 540 Overbrook Lane S.E., Grand Rapids 7
Ver Lee, Jimmie J. (A).....Galmi Hospital, Galmi Via, Madaoua, Nigeria Republic, West Africa
Ver Meulen, John (L).....2400 Wyoming, Grand Rapids
Ver Meulen, Peter (A)....105 Baynton N.E., Grand Rapids
Verwys, A. L. Hubert....815 Alger St. S.E., Grand Rapids 7
Vining, Keats K., Jr...515 Lakeside Dr. S.E., Grand Rapids
Vis, William R. (L)..26 Sheldon Ave. S.E., Grand Rapids 2
Visscher, H. C.....515 Lakeside Dr. S.E., Grand Rapids 6
Visscher, Robert D.....515 Lakeside Dr. S.E., Grand Rapids
Visser, Earl R.....124 Fulton St. E., Grand Rapids 2
Vogel, Anton.....1204 Madison Ave. S.E., Grand Rapids
Voss, John A.....2060 Alpine Ave. N.W., Grand Rapids 4
Vroon, John (A).....Takum Chr. Hospital, Pa Takum via Wukari, Makurdi, N. Nigeria, Africa
Vyn, Jay D.....7119 Driftwood S.E., Grand Rapids 6
Wahby, Elmer F.....300 Bostwick Ave. N.E., Grand Rapids

Walma, Daniel (A).....5762 Cadillac Dr,. Indianapolis 24, Ind.
Wassink, Roger N.....26 Sheldon Ave. S.E., Grand Rapids
Waterman, Donald F...515 Lakeside Dr. S.E., Grand Rapids
Webb, Clarence F.....833 Lake Dr. S.E., Grand Rapids 6
Webber, Jerome E.....50 College Ave. S.E., Grand Rapids 3
Weeber, Thomas A.....3011 Wilson S.W., Grandville
Wehrenberg, R. A. (A).....2602 Frederick Dr. S.E., Grand Rapids
Weller, Keith E.....1200 Lake Dr. S.E., Grand Rapids 6
Wells, S. Merrill Jr. (L).....2716 Bonnell Dr. S.E., Grand Rapids 6
Wenger, John N. (L).....112 Eastmanville St., Coopersville
Westendorp, Floyd..6850 Division Ave. S., Grand Rapids 8
Westerhoff, Robert J.....2740 Eastern Ave. S.E., Grand Rapids
Whinery, Jos. F.....50 College Ave. S.E., Grand Rapids 3
Whitehouse, John D.....1201 Colorado Ave. S.E., Grand Rapids 6
Whittenberger, R. N.....245 State St. S.E., Grand Rapids 3
Wiese, John L.....50 College Ave. S.E., Grand Rapids 3
Wilderom, Morris.....303 Ionia Ave. S.W., Grand Rapids
Wilkes, John B.....1328 Madison Ave. S.E., Grand Rapids 7
Wilkinson, C. A.....2030 Leonard St. N.W., Grand Rapids
Williams, John R.....1111 Conlon S.E., Grand Rapids 6
Wilson, John R.....1033 Fulton St. W., Grand Rapids
Wilson, Robert J.....1011 Fulton St. E., Grand Rapids
Wilson, Wm. E. (R).....37 Prospect Ave. N.E., Grand Rapids
Winfield, Emery D. (A).....457 Burton S.E., Grand Rapids
Winter, Garrett E.....1967 Godfrey Ave. S.W., Grand Rapids 9
Wright, Thos. B.....2614 Plainfield Ave. N.E., Grand Rapids 8
Wurz, John F.....201 Norwood Ave. S.E. Grand Rapids 6
Wyngaarden, Martin K.....245 State St. S.E., Grand Rapids 3
Yared, Jerome A.....651 Cherry St. S.E., Grand Rapids 6
Yost, William G. Jr.....50 College Ave. S.E., Grand Rapids 3
Zadvinskis, Z.....833 Lake Dr. S.E., Grand Rapids
Zimmerman, Wm. G.....26 Sheldon Ave. S.E., Grand Rapids
Zwemer, Rodger J.....1810 Wealthy St. S.E., Grand Rapids

LAPEER COUNTY MEDICAL SOCIETY (110)

Abruzzo, Anthony M.....Lapeer State Home, Lapeer
Bishop, G. Clare.....Almont
Boruch, Leon R.....Drawer A, Lapeer State Home, Lapeer
Conaway, Chas. E.....1257 N. Main St., Lapeer
Dorland, Clarke.....221 Lincoln St., Lapeer
Doty, James R.....315 Clay St., Lapeer
Greavu, Cornell Jr.....North Branch
Haney, M. Bennet.....409 E. St. Clair St., Almont
Heitsch, Wm. C.....307 Clay St., Lapeer
House, Clifford.....1750 Grey Rd., Lapeer
Kiehler, E. G., II.....1444 W. Genesee St., Lapeer
Kocur, Lubomira.....Drawer A, Lapeer St. Home, Lapeer
Lebedovych, Emil.....Drawer A, Lapeer St. Home, Lapeer
Lebedovych, Ksenia....Drawer A, Lapeer St. Home, Lapeer
Leith, Dorothy L.....240 Main St., Imlay City
Lynk, Stanley M.....4589 Lippincott, Lapeer
McBride, John R.....431 Washington St., Lapeer
Smith, Ellen.....400 White Rd. R. 1, Columbiaville
Smith, Glenn L.....6552 Imlay City Rd., Imlay City
Zemmer, H. R. (A).....Lapeer
Zolliker, Carl R. (R).....3646 Slattery Rd., Lum

LENAWEE COUNTY MEDICAL SOCIETY (114)

Abraham, A. O.....Hudson
Armovit, Herminio.....236 S. Fourth St., Onstead
Benz, Carl A.....308 N. Broad St., Adrian
Berghuis, John.....693 Stockford Dr., Adrian
Blanchard, Lowell E.....Hudson
Blanden, Merwin R.....Tecumseh
Boyd, James W.....4510 Southgate Lane, Adrian
Claxton, Wilbert T.....Britton
Coak, Richard D.....602 E. Pottawatamie St., Tecumseh
Cook, Carlton L.....603 E. Pottawatamie, Tecumseh
Diccion, R. A.....Addison
Dickman, Harry M.....104 Oak St., Hudson
Dustin, Richard E.....103 W. Brown St., Tecumseh
Eddy, Howard R. C.....Mill Rd., Adrian
Feeney, James L.....Mill St., Adrian
Fitzsimmons, Francis J.....755 High St., Adrian
Gilkey, William C.....693 Stockford Dr., Adrian
Gilmartin, Richard.....Mill St., Adrian
Greiner, Robert A.....Professional Bldg., Adrian
Hammel, Richard T.....Tecumseh
Hammersley, Gordon.....1361 Oregon Rd., Adrian
Harrison, Robt. E.....418 W. Adrian, Blissfield
Heffron, Chas. H.....231 N. Main St., Adrian
Heffron, C. Harold (A).....231 N. Main St., Adrian
Heffron, Howard H.....231 N. Main St., Adrian
Helzerman, Ralph F.....112 S. Ottawa St., Tecumseh
Hewes, Wm. H.....Mill Rd., Adrian
Hinshaw, Warren V. (A).....950 Riverside, Adrian
Locke, Francis A.....767 W. Maumee, Adrian
Miller, P. Lynford.....310 E. Maumee St., Adrian
Ocamb, Harold D.....600 E. Pottawatamie, Tecumseh
O'Connor, Archie R.....122 Locust St., Clinton
Parker, Donald A.....Bixby Hospital, Adrian
Patmos, Bernard.....127 E. Maumee St., Adrian
Phelan, Alvin J.....10 Cairns, Tecumseh
Raabe, Elmer C.....Morenci
Richey, Bert R.....765 Manitou Rd., Manitou Beach
Sarapo, Donato F.....Mill St., Adrian
Shannon, Gordon.....Blissfield
Skufis, Eleanor P.....774 College Ave., Adrian
Skufis, Xenophon.....123 E. Chestnut, Adrian
Stark, Emily S. (A).....513 E. Front St., Adrian
Stewart, Landis C.....750 High St., Adrian
Tubbs, Ray V. (A).....120 E. Adrian, Blissfield
Van Dusen, Chad A. (L).....RFD 5, Blissfield
Wentz, Patricia.....760 Riverside, Adrian
Whitehouse, Keith H.....Morenci
Wilson, Geo. C.....Box 224, Clinton
Wolf, Marvin B.....689 Stockford Dr., Adrian
Wynn, Geo. H.....1115 W. Maumee, Adrian

LIVINGSTON COUNTY MEDICAL SOCIETY (118)

Barton, Thos. A.....116 N. Michigan, Howell
Chelski, Morris.....116 W. Grand River, Brighton
Clarke, Niles A.....624 Spencer Rd., Brighton
Damstra, Donald L.....12893 E. Grand River, Brighton
Duffy, Ray M. (L).....P.O. Box 106, Pinckney
Fidler, Wm. F.....Mich. State Sanitarium, Howell
Harebottle, Norman.....Fowlerville
Hauer, R. Fred.....Fowlerville
Hendren, Jesse J. (R).....Fowlerville
Higby, Thomas F.....Fowlerville
Hill, Harold C.....116 N. Michigan Ave., Howell
Hoffman, Stanley L.....1200 Byron Rd., Howell
May, Louis E.....City Route 4, Howell
Moreno, Jose.....116 N. Michigan Ave., Howell
Perry, Florence J. C.....17640 San Rose Ave., Lathrup Village
Phillips, R. W.....Hamburg
Polack, Robt. T.....1223 Thruber Dr., Howell

Schenden, A. J. (R).....6335 W. M-36, Pinckney
Sheng, Luke H. C.....111 W. Grand River, Brighton
Smith, Russell F.....9569 Main St., Whitmore Lake
Stuber, Roscoe V.....1200 Byron Rd., Howell
Walker, Enos G.....4485 Cordley Lake, Lakeland
Wang, Stella K. C.....111 Grand River, Brighton
Woodworth, Edwin S.....1200 Byron Rd., Howell

LUCE COUNTY MEDICAL SOCIETY (122)

Cameron, Richard R.....Newberry State Hosp., Newberry
Gibson, Robt. E. L. Jr.....207 W. John St., Newberry
Gorham, Arwin.....Newberry State Hosp., Newberry
Grennan, Lawrence E.....Newberry
Hicks, R. P.....210 W. John St., Newberry
Keizer, B. G.....Newberry State Hosp., Newberry
Lasalle, Michael.....Newberry State Hosp., Newberry
Purmort, Wm. R., Jr.....Newberry State Hosp., Newberry
Surrell, Matthew A.....210 W. John St., Newberry
Thompson, Thos. W.....Newberry State Hosp., Newberry

MACOMB COUNTY MEDICAL SOCIETY (126)

Adler, Morton W.....19188 Appoline St., Detroit 35
Alexander, James H.....25815 Harper, St. Clair Shores
Alvarez, Mercedes.....11686 Eleven Mile Rd., Warren
Ambrose, Robt. H.....18801 E. Ten Mile Rd., Roseville
Arellano, Miguel A.....11868 E. Eleven Mile Rd., Warren
Audretsch, F. E.....36275 Alfred, New Baltimore
Barker, John G.....8050 Warren Blvd., Center Line
Beecher, Alvin J.....21501 Kelly, East Detroit
Biluk, Frank J.....GM Tech. Center, Warren
Bond, Franklyn F.....4861 E. Nine Mile Rd., Warren
Bower, Allen B. (L).....Armada
Bryce, James W.....25219 Van Dyke Ave., Center Line
Buckley, Danl. J.....160 S. Walnut St., Mt. Clemens
Carruthers, W. B.....303 Monitor Leader Bldg., Mt. Clemens
Chabator, George.....294 Benjamin St., Romeo
Charbeneau, Harold P.....229 S. Gratiot, Mt. Clemens
Charbonier, Luis M.....11868 E. Eleven Mile Rd., Warren
Clay, Joel W.....263 S. Gratiot Ave., Mt. Clemens
Cohen, Alan.....19750 Stansburg, Detroit
Colah, Sorab A.....708 Monitor Leader Bldg., Mt. Clemens
Collon, David, D.D.S. (A).....Romeo
Corbett, John.....225 S. Gratiot, Mt. Clemens
Cosio, Jose.....St. Joseph Hospital, Mt. Clemens
Courtney, Rufus S.....St. Joseph Hospital, Mt. Clemens
Croman, Jos. M., Jr. (R).....131 Market St., Mt. Clemens
Curatolo, Victor.....67 Cass Ave., Mt. Clemens
Darian, H. B.....11528 E. 12 Mile Rd., Warren
Deal, Harold R.....23700 Van Dyke, Warren
Deocampo, Nestor D.....11702 E. 11 Mile Rd., Warren
Depaulis, Dario C.....22770 Kelly, East Detroit
Dudzinski, Edmund J.....424 Washington St., New Baltimore
Ebner, Charles M.....26401 Harper, St. Clair Shores
Ekelman, Seymour B.....14 Belleview, Mt. Clemens
Ellias, Elmer P.....23700 Van Dyke, Warren
Engels, John A.....69311 N. Main, Richmond
Erkfitz, Arthur W.....26401 Harper Ave., St. Clair Shores
Finn, James Wm.....46056 Cass, Utica
French, Lawrence W.....25815 Harper, St. Clair Shores
Fulgenzi, Andrew A.....17301 E. Eight Mile Rd., East Detroit
Gerbasi, Francis.....81 Lochmoor Blvd., Grosse Pte. Shs.
Gesser, Charles.....20914 Kelly Rd., East Detroit
Goldin, Morris I.....6902 Chicago Rd., Warren
Goldman, Bernard J.....243 S. Gratiot Ave., Mt. Clemens
Hahne, Otto H.....13403 Thirteen Mile Rd., Warren
Hartmann, Waldemar B.....1416 S. Gratiot, Mt. Clemens
Horvath, Julius.....18019 Holland Ave., East Detroit
Hranchook, Michael.....30001 Van Dyke, Warren
Hull, Frank J.....38224 Jonathan, Mt. Clemens
Iglesias, Ernesto R.....608 Monitor Leader Bldg., Mt. Clemens
Isbey, Edward K.....25020 Van Dyke, Center Line
Ivkovich, Peter (A).....12501 E. 23 Mile Rd., Utica
Jacobs, Manuel.....23700 Van Dyke Ave., Warren
Jewell, James H.....Roseville Theatre Bldg., Roseville
Kane, John P.....67 Cass Ave., Mt. Clemens
Kane, Peter V.....67 Cass Ave., Mt. Clemens
Kane, Wm. J. (L).....171 North Ave., Mt. Clemens
Kingsley, Joyce W. Jr.....18801 Ten Mile Rd., Roseville
Kirker, J. G.....68259 Main St., Richmond
Kirtland, Wm. B., Jr.....18801 E. Ten Mile Rd., Roseville
Klein, Alfred A.....23700 Van Dyke, Warren
Knoblauch, K. H.....8425 Twelve Mile Rd. E., Warren
Kommel, Richard M.....26510 Dundee, Huntington Woods
Kripke, Morton J.....52080 Van Dyke, Utica
Kroon, Joseph D.....37984 Bonkay, Mt. Clemens
Kurtz, Hyman (A).....21414 Hillside, Mt. Clemens
Kypros, George P.....26401 Harper St., St. Clair Shores
Laporte, Lawrence A.....356 N. Clifton Rd., Birmingham
Lapp, Charles.....7817 McClellan, Utica
Levi, Charles.....8262 E. Twelve Mile Rd., Warren
Lublin, Ann.....21349 Kelly Rd., East Detroit
Maguire, Andrew J.....45569 Van Dyke, Utica
Marinelli, Ralph.....8252 E. Twelve Mile Rd., Warren
Mark, Hansi.....8236 E. 12 Mile Rd., Warren
Martin, Wm. L.....117 S. Main St., Romeo
Mattes, Max W.....18456 Wildemere, Detroit 21
Matthews, C., Jr.....14 Belleview, Mt. Clemens
Maxim, Edward S.....253 South Gratiot, Mt. Clemens
McGinty, John D.....243 S. Gratiot, Mt. Clemens
McMorrow, Kathryn.....15341 Nine Mile Rd., East Detroit
Merametdjian, Krikor.....8276 Cadillac, Warren
Merritt, Jule J.....36640 S. Gratiot Ave., Mt. Clemens
Messmer, Harold O.....7817 McClellan, Utica
Meyers, Sidney S.....28477 Hoover, Warren
Miller, Sidney S.....28477 Hoover Rd., Warren
Moore, Geo. F. (L).....69434 N. Forest, Richmond
Morris, Gerald W.....14 Belleview, Mt. Clemens
Mulligan, Philip T.....612 Monitor Leader Bldg., Mt. Clemens
Nance, Marion E.....16666 14 Mile Rd., Fraser
Neiswander, Paul L.....Fisher Body Div. GMC, Warren
Nutting, Helen M.....22631 Greater Mack, St. Clair Shores
O'Shee, Vincent.....8216 E. Twelve Mile Rd., Warren
Oughtred, Orville.....26401 Harper, St. Clair Shores
Pacho, Marc.....27075 Gail, Warren
Paris, Delmo A.....18801 E. Ten Mile Rd., Roseville
Parmelee, N. H.....52080 Van Dyke Ave., Utica
Perez, Florence.....27075 Gail, Warren
Porretta, Anthony C.....25255 Ronald, Roseville
Ramos, Antonio E.....29846 Schoenherr, Warren
Reichman, Jos. J.....1455 Sheffield, Saginaw
Reitzel, Rufus H.....199 S. Gratiot Ave., Mt. Clemens
Reizen, Maurice S.....10564 Ludlow, Huntington Woods
Revere, Jos. O.....192 S. Gratiot Ave., Mt. Clemens
Rickman, Lewis D.....14 Howard, Mt. Clemens
Riddle, Charles B.....620 Eastland Prof. Bldg., Harper Woods
Rinkenberger, E. A.....243 S. Gratiot Ave., Mt. Clemens
Rivkin, Jos.....14 Belleview, Mt. Clemens
Rizzo, Albert.....21321 Harper, St. Clair Shores
Rooney, Robert.....23700 Van Dyke, Warren
Roth, Geo. E.....19136 Mendota Ave., Detroit 21
Rothman, Arthur M.....22422 Gratiot Ave., East Detroit
Rourke, Ronald E.....21503 Harper Ave., St. Clair Shores

Rousseau, Daniel L.....Monitor Leader Bldg., Mt. Clemens
Ruedisueli, C. A.....19 Breitmeyer Pl., Mt. Clemens
Rush, Wm. E.....25815 Harper, St. Clair Shores
Ryan, Jack.....23700 Van Dyke Ave., Warren
Ryan, Thomas E.....5518 Eastlawn, Detroit 13
Salot, Russell F.....67 Cass Ave., Mt. Clemens
Samet, Norman.....310 Monitor Leader Bldg., Mt. Clemens
Sarnacki, Carl J.....8425 Twelve Mile Rd. E., Warren
Scher, Jos. N.....130 Cass Ave., Mt. Clemens
Scher, Sydney.....132 Cass Ave., Mt. Clemens
Schmunk, Robert F.....136 Cass Ave., Mt. Clemens
Shaya, Ezra S.....31170 Hoover, Warren
Siegfried, Edward G.....229 S. Gratiot Ave., Mt. Clemens
Simmons, Milton F.....12500 E. Twelve Mile Rd., Warren
Sims, Wm. N.....229 S. Gratiot Ave., Mt. Clemens
Singer, Nelson.....22100 Gratiot Ave., East Detroit
Stanton, James.....225 S. Gratiot Mt. Clemens
Starbird, Wm. A.....8216 E. 12 Mile Rd., Warren
Starkman, Morris.....28477 Hoover, Warren
Steele, George H.....229 S. Gratiot, Mt. Clemens
Steinberger, Eugene.....23700 Van Dyke, Warren
Stepka, Joseph E.....7817 McClellan, Utica
Stief, Kirwin.....66 Riverview, Mt. Clemens
Stone, Elizabeth A.....Romeo
Stone, Julius.....67 Cass Ave., Mt. Clemens
Stone, Sanford.....4050 E. 12 Mile Rd., Warren
Stryker, Oscar D.....43525 Elizabeth Rd., Mt. Clemens
Sturm, Fredk. A.....76 Lochmoor, Grosse Pointe 36
Suksta, Adolph W.....23250 Gratiot, East Detroit
Suzuki, M.....23700 Van Dyke, Warren
Teahan, Robert.....50500 Mound Rd., Utica
Thompson, Alfred A.....126 Cass Ave., Mt. Clemens
Tinkey, L. Leo.....8306 Twelve Mile Rd., Warren
Transue, David.....20963 Kelly, East Detroit
Trinkaus, Wm. F.....22033 Kelly Rd., East Detroit
Urbancic, William.....24605 Almond, East Detroit
Weiss, Jack I.....23700 Van Dyke Ave., Warren
Whitley, Alec.....30233 Jefferson Ave., St. Clair Shores
Wiley, D. Bruce.....46056 Cass Ave., Utica
Witus, Carl.....21349 Kelly Rd., East Detroit
Wolf, Ervin.....17819 Homer St., Roseville
Wyte, Wm. C.....263 S. Gratiot Ave., Mt. Clemens
Yamasaki, Ken.....23700 Van Dyke, Warren
Zavela, Dan.....679 N. Renaud, Grosse Pts. Wds.
Zook, Gilbert E. (A).....253 S. Gratiot, Mt. Clemens
Zucker, Norman.....27225 Little Mack, St. Clair Shores

MANISTEE COUNTY MEDICAL SOCIETY (130)

Futterer, Le Roy A.....Forest Clinic Bldg., Manistee
Garneau, Robt. R.....Forest Clinic Bldg., Manistee
Gunderson, Edw. P., Jr.....Greenbush St., Manistee
Hansen, Ernest C.....326 First St., Manistee
Kiley, James A.....310 9th St., Manistee
Konopa, John F.....57 Poplar St., Manistee
Miller, Ernest B.....326 First St., Manistee
Oakes, Ellery A. (R).....576 Bryant Ave., Manistee
Ramsdell, Homer A. (L).....398 River St., Manistee
Rosenow, K. G.....Forest Clinic Bldg., Manistee
Schwarz, Marlowe L.....Onekama
Schwing, Donald N.....Forest Clinic Bldg., Manistee
Wild, David A.....310 9th St., Manistee

MARQUETTE-ALGER COUNTY MEDICAL SOCIETY (134)

Acocks, James R.....Morgan Hgts. Sanat., Marquette
Amolsch, Arthur L.....1008 Bluff St., Marquette
Bennett, Arthur K. (L).....Box 436, Mt. Dora, Fla.
Bennett, Matthew C.....Medical Building, Marquette
Berry, Robt. F.....Medical Building, Marquette
Bertucci, Jos. P.....114 S. First St., Ishpeming
Bolitho, Thos. B.....Medical Bldg, Marquette
Carefoot, Rankin L.....St. Lukes Hospital, Marquette
Carter, James M.....Medical Building, Marquette
Casler, Wilbur L. (L).....131 E. Ridge St., Marquette
Celori, Luciano.....315 N. Front St., Marquette
Conley, Donal T.....1st Natl. Bank Bldg., Marquette
Cooperstock, Moses.....Medical Building, Marquette
Corcoran, Wm. A. (L).....200 S. Main Street, Ishpeming
D'Adesky, R. G.....2340 N.E. 53rd, Ft. Lauderdale, Fla.
Drom, Robert E. (A).....829 Croix, Negaunee
Drury, Chas. P. (R).....416 E. Hewitt Ave., Marquette
Elzinga, Eugene R.....315 N. Front St., Marquette
Green, Southgate J.....Gwinn
Hettle, Paul J.....211 Savings Bank Bldg., Marquette
Hornbogen, Danl. P.....101 S. Front St., Marquette
Howe, Lloyd W. (L).....101 S. Front St., Marquette
Huffman, Elston R.....427 W. College, Marquette
Hulse, Robert C.....210 E. Superior St., Munising
Humphrey, William C.....829 Croix Street, Negaunee
Jaedecke, Robt. G.....829 Croix, Negaunee
Kane, Elizabeth D.....418 W. Magnetic, Marquette
Knutson, Geo. O. (A).....125 E. Main St., Negaunee
Koenig, Harry.....116 S. Main St., Ishpeming
Kronschnabel, E. F.....Medical Bldg., Marquette
Lambert, Warren C.....Medical Building, Marquette
Lexmond, M. J.....524 Mather Ave., Ishpeming
Lindquist, Leo A.....Medical Bldg., Marquette
Lyons, James W.....803 N. 3rd St., Marquette
Matthews, Norman L.....N. Mich. Child. Clinic, Marquette
Mudge, Thomas J.....Medical Building, Marquette
Mudge, Wm. A. (L).....108 Ridge St., Negaunee
Narotzky, Archie S.....Miracle Circle, Ishpeming
Niemi, Osmo.....No. Michigan Univ., Marquette
O'Brien, Francis D. (M).....154 Explorer, KI Sawyer AFB
Olson, Walter R.....Sand Point Rd., Munising
Paine, Raymond L.....416 Teal Lake Ave., Negaunee
Pearson, Wallace G.....909 W. Magnetic, Marquette
Rosenbaum, Louis.....540 E. Division, Ishpeming
Sabin, Fredk. C.....101 S. Front St., Marquette
Schmidt, Merle C. (A).....Medical Bldg., Marquette
Schroeder, W. Gene.....745 Mathe Ave., Ishpeming
Schweinsberg, Sara K. D. (A).....507 Bemis Rd., RFD, Saline
Strum, Gerald (M)..56th USAF Hospital, KI Sawyer AFB, Gwinn
Tearnan, Raymond A. (L).....Munising
Tobin, James F., Jr.....776 Mather Ave., Ishpeming
Van Riper, Paul (L).....Champion
Wall, David R.....Aitamont & Fisher, Marquette
Williams, Reginald G.....524 Mather St., Ishpeming
Wilson, George M., Jr.....Medical Building, Marquette
Wright, Kenneth C.....Medical Building, Marquette

MASON COUNTY MEDICAL SOCIETY (138)

Bacon, Herbert G., Jr.....101 N. Main, Scottville
Boon, A. Floyd.....203 N. Ferry, Ludington
Carney, John R.....202 N. Park St., Ludington
Carney, Ruth V. C.....202 N. Park Ave., Ludington
Castellani, R. J.....P.O. Box 349, Ludington
Clark, Harry L. (L).....510 N. Lakeshore Dr., Ludington
Craymer, Austin.....420 N. Rath, Ludington
Ewing, R. L.....600 Tinkham Ave., Ludington
Hoffman, Howard B.....604 E. Ludington Ave., Ludington
Kellawan, Karl K.....Scottville
Kleinschmidt, Gladys J.....401 E. Ludington Ave., Ludington
Martin, Wm. S.....107 Ludington, Ludington
Mayer, Gerry.....600 Tinkham Ave., Ludington
Morrow, Wm. J.....119 N. James St., Ludington
Ostrander, Robt. A.....Lakewood Dr., C7, Ludington
Paukstis, Chas. A.....111 E. Court St., Ludington
Sutter, Wm. F.....220 S. James St., Ludington

MECOSTA-OSCEOLA-LAKE COUNTY MEDICAL SOCIETY (142)

Bruggema, Jacob.....Main St., Evart
Franklin, Benj. L. (L).....Remus
Haldeman, Jack.....1014 S. State St., Big Rapids
Hickox, Leland A.....1014 S. State St., Big Rapids
Ivkovich, Paul.....Reed City
Kilmer, Paul B.....Reed City
Kowaleski, Edward H.....Remus
Lincoln, Norman V.....Reed City
Merlo, Frank A.....206 S. Michigan St., Big Rapids
Nelson, Lorenzo R.....RFD 1, Baldwin
Pratt, Gordon C.....Ferris Institute, Big Rapids
Tyson, James L.....1014 South State St., Big Rapids
Van Auken, Edward W.....229 S. Warren, Big Rapids
Walters, James E.....1014 S. State St., Big Rapids
White, John A.....121 S. Michigan St., Big Rapids

MEDICAL SOCIETY OF NORTH CENTRAL COUNTIES (150)

Backe, John C. (R)..6401 N. Fifth Ave., St. Petersburg, Fla.
Baker, Ophelia P.....199 Fairview, West Branch
Baker, Thomas A.....199 Fairview, West Branch
Barstow, Richard G.....Gaylord
Blaha, Vernon B.....Grayling
Boehm, John D. (R).....West Branch
Bontrager, W. E.....Mio
Christensen, D. E.....N. Mich. TB San., Gaylord
Clippert, C. G. (R).....308 Michigan Ave., Grayling
Coulter, Keith D.....Box 138, Alden
Crandell, Clare H. (R).....West Branch
Forney, Fred A. (L).....Saginaw County Hosp., Saginaw
Godfroy, Bernard.....Roscommon
Hasty, Earl A.....West Branch
Hayes, Louis F.....Gaylord
Henig, Benj. E.....Grayling
Howarth, Thos. W.....Gladwin
Jardine, Hugh M.....West Branch
Libke, Robert S.....Gaylord
Martens, Elvina.....Box 17, Fairview
Oppy, Charles L.....Roscommon
Peckham, Richard C.....Gaylord
Potvin, Clifford D.....Grayling
Rusak, R. D.....Gladwin
Schaiberger, Geo. L.....West Branch
Stealy, Stanley A.....Grayling
Timreck, Harold A.....Gladwin
Van Oosten, Howard E.....117 Burgess, West Branch
Wiegerink, L. T.....West Branch

MENOMINEE COUNTY MEDICAL SOCIETY (146)

Agneberg, Nils O.....531 1st St., Menominee
Anderson, N. O. (A).....Daggett
Brukardt, Herman R.....534 First St., Menominee
Dewane, Francis J.....413 10th Ave., Menominee
Glickman, L. Grant.....958 First St., Menominee
Gonty, Arthur.....St. Joseph Lloyd Hosp., Menominee
Heidenreich, John R.....Daggett
Hopson, George H.....104 Tenth Ave., Menominee
Hopson, Patricia C.....104 Tenth Ave., Menominee
Jones, Wm. S.....1146 Tenth Ave., Menominee
Jones, Wm. S., Jr.....1146 Tenth Ave., Menominee
Kerwell, Karm C. (L).....P.O. Box 17, Stephenson
Olson, Robt. C.....828 Tenth Ave., Menominee
Rogers, Raymond J.....205 1st St., Menominee
Towey, John W. (L)....1717 Orchid Lane, Middleton, Wisc.

MIDLAND COUNTY MEDICAL SOCIETY (154)

Athay, R. M. (R).....4622 Concord Ct., Midland
Ballmer, Robt. S.....2715 Ashman St., Midland
Benjamin, Mac B.....307 Cass St., Sanford
Bernier, Jos. A.....218 E. Railway, Sanford
Blackhurst, J. F.....2715 Ashman St., Midland
Blackhurst, Robt. T.....Blackhurst Bldg., Midland
Bowsher, Robt. E.....2719 Ashman St., Midland
Bridge, Robt. G.....2715 Ashman, Midland
Bulmer, Dan J.....116 Harold St., Midland
Bush, Raymond C.....808 W. Sugnet, Midland
Buskirk, Maurice D.....110 W. Sugnet, Midland
Cline, J. Daniel.....504 Linwood Dr., Midland
Devlin, James A.....115 Jerome, Midland
Ellis, Ruth.....2510 Ashman, Midland
Fields, Dozier N., Jr.....515 W. Main St., Midland
Gay, Harold H.....Dow Chemical Co., Midland
Goethe, Roy M.....110 W. Sugnet, Midland
Gordon, Harold L.....Dow Chemical Co., Midland
Grant, Robert.....116 Harold St., Midland
Grewe, Norman C.....501 E. Pine St., Midland
Haberstroh, Colleen.....907 Eastman Rd., Midland
Harrigan, William E.....2706 Louanna, Midland
Heffernan, D. D.....402 Dartmouth, Midland
Holder, Benj. B.....Dow Chem. Co. Med. Dept., Midland
Howe, Irvin M.....110 W. Sugnet, Midland
Howell, Richard H.....2719 Ashman, Midland
Ittner, Martin J.....217 N. Saginaw Rd., Midland
Kramer, Chas. G.....Box 469, Dow Chemical, Midland
Kremski, John A.....Midland Hospital, Midland
Kwast, Harold A.....2715 Ashman, Midland
Linsenmann, Karl W.....2604 Manor Dr., Midland
Marks, Virginia A.....2706 Louanna, Midland
Maynard, Wm. A.....208 N. Fourth, Coleman
Meisel, Edward H., Jr.....Masonic Bldg., Midland
Moench, G. Fredk.....147 Center St., Sanford
O'Hora, Bernard A.....110 W. Sugnet Rd., Midland
Ohorodnik, Julius M.....109 Capitol Drive, Midland
Pike, Melvin H.....224 E. Larkin, Midland
Pollock, Robert.....Masonic Bldg., Midland
Poznak, Leonard A.....4005 Orchard Dr., Midland
Randolph, Stephen H.....201 E. Ellsworth St,. Midland
Redmon, William B.....115 Jerome, Midland
Schoff, Charles A.....2706 Louanne, Midland
Shriner, John W.....902 E. Ashman, Midland
Smock, Sidney N.....3911 Moorland Drive, Midland
Stewart, Richard.....Dow Chemical Co., Midland
Thamarus, W. E., Jr.....5801 Highland Dr., Midland
Towsley, Wilbur D.....515 W. Main St., Midland
Ulmer, George.....4005 Orchard, Midland
Westphal, Harry O.....3102 Swede Rd., Midland
Willison, Chas. H.....122 Townsend St., Midland
Yobst, G. James.....2719 Ashman, Midland

MONROE COUNTY MEDICAL SOCIETY (158)

Ames, Florence D.....2 W. Noble Ave., Monroe
Barrett, C. D., Sr.....Court House, Monroe
Black, Charles E.....721 N. Macomb St., Monroe
Blakey, Leonard C.....745 N. Monroe St., Monroe
Bond, Wm. W.....222 N. Monroe St., Monroe
Burroughs, J. J.....745 N. Monroe St., Monroe
Cigany, Zoltan B.....Carleton
Clark, Bruce.....8308 Lewis Ave., Temperance

Diehl, George Z.....721 N. Macomb, Monroe
Douglas, Dale W.....19 E. First St., Monroe
Dranginis, E. J.....Monroe Hospital, Monroe
Ewing, Robt. T.....130 Maple Blvd., Monroe
Flanders, John P.....31 Washington St., Monroe
Frary, Reginald A.....505 Strasburg, Monroe
Freud, John W.....1262 N. Macomb St., Monroe
Golden, Jean Dace.....304 Washington St., Monroe
Hensel, Hilda M.....12 E. 4th St., Monroe
Hnatchuk, Nicholas.....8079 Summerfield, Lambertville
Johnson, A. Esther.....751 N. Monroe St., Monroe
Kelso, S. Newton, Jr.....753 N. Monroe St., Monroe
King, John R.....12 East 4th St., Monroe
Laboe, Edward W.....424 Hollywood, Monroe
Lammers, Gerald P.....Ida
Liedel, Warren J.....725 N. Monroe St., Monroe
Loan, G. B.....429 N. Monroe St., Monroe
Long, Edgar C.....1310 N. Macomb St., Monroe
Lusher, William T.....8308 Lewis Ave., Temperance
McGeoch, Reginald W.....718 N. Macomb St., Monroe
McMillin, John H.....423 E. Elm St., Monroe
Meier, Walter A.....15463 S. Monroe St., Monroe
Middleton, W. S.....219 W. Front St., Monroe
Ozdaglar, Mehmet N.....721 N. Macomb, Monroe
Pinkus, Hermann K. B.....12 E. 4th St., Monroe
Reisig, Albert H.....1 S Monroe St., Monroe
Sisman, Bernard.....749 N. Monroe St., Monroe
Stephenson, Joy O.....721 N. Macomb St., Monroe
Streicher, Robt. G.....729 N. Monroe St., Monroe
Wagar, Spencer H.....31 Washington St., Monroe
Weeks, Vernon L.....326 N. Monroe, Monroe
Wilkins, Rolland W.....757 N. Monroe St., Monroe
Williams, Robt. J.....31 Washington St., Monroe
Wood, Russell J.....314 Richards, Monroe

MUSKEGON COUNTY MEDICAL SOCIETY (162)

Allen, Richard T.....768 W. Broadway, Muskegon Heights
Alt, William J.....Medical Arts Center, Muskegon
Askam, Ralph F.....Medical Arts Center, Muskegon
Atkinson, Annie L.....1019 Green Creek Rd., North Muskegon
August, Ralph V.....72 E. Broadway, Muskegon Heights
Barnard, Helen S.....33 Diana, Muskegon
Barnes, James W.....102 Professional Bldg., Montague
Barnett, James M.....2416 Peck St., Muskegon Heights
Benedict, Arthur L., Jr.....22 W. Southern Ave., Muskegon
Bloom, Robt. E.....Medical Arts Center, Muskegon
Bolthouse, Robt. E.....2101 Peck St., Muskegon Heights
Bond, Wm. H.....1282 Arthur St., Muskegon
Boyd, De Vere R.....1735 Peck St., Muskegon
Boyd, Jack L.....450 W. Western Ave., Muskegon
Bradshaw, Park S.....Medical Arts Center, Muskegon
Bultema, James H.....Medical Arts Center, Muskegon
Busard, J. Max.....1200 Ransom, Muskegon
Busard, Thos. R.....Medical Arts Center, Muskegon
Carlson, Mr. James C. (A).....2060 Belmont, Muskegon
Chapin, Wm. S. (A).....2136 Sanford, Muskegon Heights
Christophersen, J. W.....1276 Lake Shore Dr., Muskegon
Clapp, Henry W.....88 Strong Ave., Muskegon
Clifford, James D. (A).....452 Maple, Plymouth
Closz, Harold F. (L).....1727 Jefferson St., Muskegon
Clowater, Robert A.....1092 Holton Rd., Muskegon
Cornell, Homer E.....870 N. Second, South Muskegon
Crawford, John W., Jr.....Medical Arts Center, Muskegon
Cronick, Anne B.....435 Whitehall Rd., Muskegon
Dart, Dorothy O.....3956 Whitehall Rd., Muskegon
Dasler, Adolph F.....1507 Peck St., Muskegon
De Leeuw, Henry.....4090 Higate Rd., Muskegon
Diskin, Frank.....1324 Marquette Ave., Muskegon
Dykhuizen, H. D.....289 W. Western Ave., Muskegon
Ellis, Nicholas J.....1891 Lake Shore Dr., Muskegon
Engstrom, Albert D.....126 W. Colby, Whitehall
Farmer, John C.....Medical Arts Center, Muskegon
Fillingham, Enid (R).....1034 Giles Rd., Muskegon
Findorff, William G.....Medical Arts Center, Muskegon
Fleischmann, Chas. B. (L).....250 W. Webster Ave., Muskegon
Fles, Robt. J.....1715 Peck St., Muskegon
Folsom, John D.....1706 Peck St., Muskegon
Frandsen, Philip H.....Medical Arts Center, Muskegon
Fugate, E. M.....Medical Arts Center, Muskegon
Gaikema, Everett W. (R)....605 First St., North Muskegon
Garber, Frank W., Jr.....Hackley Union Bldg., Muskegon
Garber, Frank W.....235 Monroe Ave., Muskegon
Garrison, Robt. E., Jr.....126 W. Webster Ave., Muskegon
Giese, Douglas H.....204 Mich. Theater Bldg., Muskegon
Gillard, James L.....1642 Peck St., Muskegon
Goltz, Martha H. (L).....Montague
Gouwens, W. E., Jr.....Medical Arts Center, Muskegon
Griffith, Robt. M.....68 E. Broadway, Muskegon Heights
Hack, Donald W.....Medical Arts Center, Muskegon
Hanley, Wm. J.....315 W. Clay Ave., Muskegon
Harryman, James E.....1200 Ransom St., Muskegon
Hartwell, Shattuck W.....450 W. Western Ave., Muskegon
Harvey, John G. Klemm.....Mercy Hospital, Muskegon
Heneveld, Edward H.....1603 Peck St., Muskegon
Heneveld, John (R).....Brasstown, N. C.
Heneveld, Robt. G.....Medical Arts Center, Muskegon
Hennessy, Mary E. (A).....1200 Ransom St., Muskegon
Herald, Osbie J.....1075 Jefferson St., Muskegon
Holly, Leland E.....876 N. Second St., Muskegon
Holly, Leland E., II.....878 N. Second St., Muskegon
Hornbeck, Wm. J.....1200 Ransom St., Muskegon
Huntley, Richard A.....1704 W. Sherman Blvd., Muskegon
Jesson, Robt. M.....1200 Ransom St., Muskegon
Johnston, E. H.....878 N. Second St., Muskegon
Joistad, Arthur H., Jr.....878 N. Second St., Muskegon
Kane, Thos. J. (M).....2086 Leimert Blvd., Oakland 2, Calif.
Kay, Cecelia S.....932 Second St., Muskegon
Keilin, Marie (L).....307 Liberty Life Bldg., Muskegon
Kerr, Howard J.....3054 Henry St., Muskegon
Kislov, Richard.....Medical Arts Center, Muskegon
Kleaveland, Ingram J.....1670 Peck St., Muskegon
Krenz, Marlin P.....Hackley Union Bk. Bldg., Muskegon
Lange, Eugene W.....337 N. Muskegon Blvd., Muskegon
Lapham, Landon M.....123 W. Colby, Whitehall
Lauretti, Emil J.....Medical Arts Center, Muskegon
Lauretti, L. A.....936 Second St., Muskegon
Laurin, Vilda S. (L).....Medical Arts Center, Muskegon
Le Fevre, Geo. L., Jr. (R)..726 Lake Dr., North Muskegon
Le Fevre, Wm. M.....315 W. Clay Ave., Muskegon
Lemmen, Lloyd J.....3924 Henry St., Muskegon
Leonard, Mr. A. T. (A).....435 Whitehall Rd., Muskegon
Loder, Leonel L.....289 W. Western Ave., Muskegon
Lott, James S.....878 Second St., Muskegon
Lowry, Robt. A.....2336 Peck St., Muskegon Heights
Maire, Lewis E.....1633 Peck St., Muskegon
Mandeville, C. B. (L).....815 Hackley Union Bldg., Muskegon
Marrs, Jack Winton.....Med. Arts Bldg., Muskegon
McNair, John N.....936 Second St., Muskegon
Medema, Paul E.....1017 Sanford St., Muskegon
Meengs, Marvin B.....1725 Peck St., Muskegon
Miller, Phillip L.....1755 Peck St., Muskegon
Mulder, Lambertus.....Medical Arts Center, Muskegon
Mulligan, Alan W. (R)....123 West Larch Ave., Muskegon
Oden, C. L. A. (L).....Medical Arts Center, Muskegon
Parsons, Frank W.....315 W. Clay Ave., Muskegon
Paterson, Lester C.....1643 Peck St., Muskegon
Peterson, Wm. F.....1094 Jefferson St., Muskegon
Pettinga, Frank L.....1603 Peck St., Muskegon
Prentice, Edwin W.....1017 Sanford St., Muskegon
Risk, Robt. D.....1160 Ransom St., Muskegon
Sanden, Howard V.....1643 Peck St., Muskegon
Scholle, Norbert W.....2500 Peck St., Muskegon Heights
Shebesta, Emil M.....Medical Arts Center, Muskegon
Smith, Robert E.....Medical Arts Center, Muskegon
Steffee, William P.....402 Center St., N. Muskegon
Stubbart, F. James.....2416 Peck St., Muskegon Heights
Sweda, George P.....Health Dept. Co. Bldg., Muskegon
Swedenburg, Robt. D.....503 Liberty Life Bldg., Muskegon

Swenson, Leland L.....1706 Peck St., Muskegon
Tellman, H. Clay.....302 Med. Arts Center, Muskegon
Thieme, Siegfried W. (L).....12213 Stafford St., Ravenna
Thornton, Eugene S. (L)....301 E. Circle Dr., N. Muskegon
Toy, Chas. M.....1067 Pine St., Muskegon
Tyler, Wm. H.....1435 Peck St., Muskegon
Vandervelde, C. A.....283 W. Western Ave., Muskegon
Vangelder, Wm. C.....Medical Arts Center, Muskegon
Voikos, Geo. A.....179 Strong Ave., Muskegon
Wagenaar, Edward H.....3054 Henry St., Muskegon
White, Warren G., Jr.....1624 Peck St., Muskegon
Wiersma, Silas C.....Medical Arts Center, Muskegon
Wildgen, Bernard C.....Medical Arts Center, Muskegon
Wilke, Carl A. (R).....(Address Unknown)
Williams, Dale L. (A).....1107 Hendricks Rd., Muskegon
Williams, Edward V.....2501 Baker St., Muskegon Heights
Wilson, B. David (A).....15428 Archdale, Detroit 27
Young, Malcolm C.....1700 Clinton St., Muskegon

NEWAYGO COUNTY MEDICAL SOCIETY (166)

Crowe, Findlay C.....Rt. 1, Hunterbrook Rd., Yorktown Heights, N. Y.
Decker, J. C.....Grant
Deur, Theodore R.....Grant
De Young, Jess.....111 W. Dayton, Fremont
Emerick, Robt. W.....Gerber Memorial Hosp., Fremont
Geerlings, Lambert J. (L).....20 N. Division St., Fremont
Klein, J. Paul.....P.O. Box 111, Fremont
Masters, Brooker L.....111 W. Dayton, Fremont
Moore, Hugh R.....Newaygo
O'Neill, John W.....Dist. Health Dept. 5, White Cloud
Painter, Robert.....Grant
Paxton, Robt. E.....40 W. Sheridan, Fremont
Pedelty, Norman.....Newaygo
Vanden Berg, Tunis.....20 N. Division Ave., Fremont
Veenschoten, Girard.....Hesperia

NORTHERN MICHIGAN MEDICAL SOCIETY (170)

Allen, Robt. F.....Lockwood Hosp., Petoskey
Alm, Bernhard T.....418 Petoskey St., Petoskey
Blum, Benj. B.....1208 E. Mitchell, Petoskey
Burns, Dean C.....215 Division, Petoskey
Conkle, Guy C. (L).....Masonic Bldg., Boyne City
Conklin, Frederic L. (A)....Lockwood Gen. Hosp., Petoskey
Connaughton, P. J.....314 Spencer, Petoskey
Conti, Jos. B.....924 E. Mitchell St., Petoskey
Conway, Wm. S.....910 E. Mitchell, Petoskey
Crippen, Edward F. (A).....Rt. 1, Mancelona
Drake, Gerald.....511 Waukazoo, Petoskey
Duffie, Don H. (L).....1018 Colby St., Mandison, Wis.
Elliott, Dean C.....Arlington Heights, Petoskey
Foster, Bradford S.....226 Park, Petoskey
Fulmer, Roger C.....Petoskey Rd., Harbor Springs
Grate, Lawrence E.....112 Clinton, Charlevoix
Hegener, Aloysius J.....1020 Howard, Petoskey
Homsi, Rateb.....802 S. Main St., Cheboygan
Inyart, Jack R.....Mancelona
Kirk, Thomas R.....West Sheridan Rd., Petoskey
Knecht, Richard A.....226 Park Ave., Petoskey
Kutcipal. R. A.....1018 Lindell, Petoskey
Larson, Walter E.....456 S. Huron, Cheboygan
Lawrie, Guy K.....816 S. Citrus Ave., West Covina, Calif.
Lentini, Nicholas.....Cheboygan
Lignell, John H.....Rt. 3, Division St., Charlevoix
Litzenburger, A. F.....411 Pearl St., Boyne City
Martin, Robt. G.....707 Bridge, Charlevoix
Mateskon, Victor S.....Sunset Blvd, Petoskey
Mayne, Frederick C. (L).....P.O. Box 387, Cheboygan
McCullough, W. L.....115 Clinton, Petoskey
McEnroe, John E.....1005 E. Mitchell, Petoskey
McKnight, Robt. D.....Lincoln Place, Petoskey
Mertz, Joanne E.....Resort Pike, Petoskey
Park, Richard .....Burns Clinic, Petoskey
Pearson, Robt. E.....215 Water St., Boyne City
Postle, Jack R.....Arlington Heights, Petoskey
Rauch, Carl T.....420 Riverside Dr., Cheboygan
Reus, Leonard W.....226 Park Ave., Petoskey
Rodger, John R.....Bellaire
Saltonstall, G. B.....112 Clinton St., Charlevoix
Savory, John H.....East Jordan
Schaefer, Joseph C.....1133 Valley View, Petoskey
Shanahan, Robt. E.....1015 Lindell Ave., Petoskey
Sheets, John A.....1111 E. Mitchell, Petoskey
Smith, James R.....901 Spruce St., Petoskey
Snide, Rollin F.....125 N. Main St., Cheboygan
Spengler, John R.....1111½ E. Mitchell, Petoskey
Stringham, James R. (L).....225 Backus St., Cheboygan
Taylor, Robt. M.....Lincoln Place, Petoskey
Uhlich, Gustav A.....E. Mitchell Rd., Petoskey
Van Dellen, Jerrian.....Water St., East Jordan
Webster, Jean H.....200 Sunset St., Petoskey
Weburg, Kathryn D.....Burns Clinic, Petoskey
Zipf, Charles.....Douglas Lake, Pellston

OAKLAND COUNTY MEDICAL SOCIETY (174)

Abbott, Vernon C.....1405 Pontiac St. Bk., Pontiac
Adair, Robin.....800 S. Adams, Birmingham
Adams, Fredk. M.....800 S. Adams, Birmingham
Albert, Donald G.....1665 Twelve Mile Rd., Berkley
Albrecht, Robt. W.....2111 Cass Lake Rd., Keego Harbor
Altshuler, Ira M. (L).....17600 W. 8 Mile, Southfield
Anaya, Jacinto M. (A).....Pontiac State Hosp., Pontiac
Anderson, Alexander S.....602 N. Woodward, Birmingham
Arena, Joseph A., Jr.....31815 Southfield Rd., Birmingham
Arnkoff, Harry.....45 W. Huron St., Pontiac
Ashare, Raymond.....35 S. Johnson, Pontiac
Aulie, Hal G.....420 Washington Sq. Bldg., Royal Oak
Awes, Lorraine E.....35 S. Johnson, Pontiac
Baier, Kurt.....2186 Garland, Pontiac 19
Baker, Frederick A. (L).....4575 Motorway Dr., Pontiac
Bannow, Robt. J.....880 Woodward Ave., Pontiac
Barker, Chas. P.....214 Wabeek Bldg., Birmingham
Barker, Howard B. (L).....880 Woodward Ave., Pontiac
Barlow, Peter P.....31815 Southfield Rd., Birmingham
Barnes, Donald J.....717 W. Ten Mile Rd., Pleasant Ridge
Barr, Norman L.....965 Orchard Ridge Rd., Bloomfield Hills
Barrett, John L.....800 S. Adams, Birmingham
Barron, Robert A.....4085 Pontiac Trail, Orchard Lake
Bauer, Bruce D.....22643 Stephenson Hwy., Hazel Park
Bauer, Edward G.....101½ N. Saginaw, Pontiac
Bauer, Ernest W., Sr.....22643 Stephenson Hwy., Hazel Park
Bauer, Ernest W., Jr.....22643 Stephenson Hwy., Hazel Park
Bauer, Franz.....909 Woodward Ave., Pontiac
Baylis, Shelby M.....35 S. Johnson, Pontiac
Beattie, Willard G. (R).....2500 Sample Rd., Pompano Beach, Fla.
Beck, Otto O. (L).....308 Wabeek Bldg., Birmingham
Becker, Paul M.....1890 Southfield Rd., Birmingham
Belknap, Warren F.....1809 S. Main St., Pleasant Ridge
Berg, Richard M.....880 Woodward Ave., Pontiac
Berger, Chas. J.....17220 W. Eight Mi. Rd., Southfield
Berkman, Ruth.....31555 W. Ten Mile Rd., Farmington
Berman, Bernard D.....1070 N. Telegraph Rd., Pontiac
Berman, Gilbert M.....22100 Coolidge, Oak Park
Beuker, John T.....1100 N. Woodward Ave., Birmingham
Beyer, Hans A.....5675 Kolly Rd., Birmingham
Birkelo, Carl H.....4680 Dixie Hwy., Drayton Plains
Blakey, John M. (A)....Wm. Beaumont Hospital, Royal Oak
Blanchard, Gerald E.....GMC Pontiac Mtr. Div., Pontiac

Blue, Jane.....19125 Hillcrest, Birmingham
Blunt, Lynn Waldo (A).....1035 Island Dr., Ann Arbor
Boesky, Malcolm D.....26789 Woodward Ave., Huntington Woods
Boileau, Thornton I.....2075 E. 14 Mile Rd., Birmingham
Bookmyer, Robt M.....31815 Southfield Rd., Birmingham
Boucher, Roman E.....4200 N. Woodward Ave., Royal Oak
Bowers, Chas. L.....909 Woodward Ave., Pontiac
Brady, Neal C.....19040 Riverside Dr., Birmingham
Bronson, Wm. W.....28119 John R St., Madison Heights
Brown, Arnold L.....35 S. Johnson, Pontiac
Browne, Richard T. (A).....2421 Evergreen Dr., Royal Oak
Bryant, F. W.....201 Washington Sq. Bldg., Royal Oak
Budd, Alexander S. Z...3511 Lakecrest Dr., Bloomfield Hills
Buehrig, Robert.....5790 M 15, Clarkston
Bullard, R. W., Jr.....5790 M 15, Clarkston
Burger, John H.....31815 Southfield Rd., Birmingham
Burgess, Bruno.....29250 Longview St., Warren
Burke, Chauncey G.....35 W. Huron St., Pontiac
Byberg, Robt. A.....420 Washington Sq. Bldg., Royal Oak
Cabrera, G. P.....420 Washington Sq. Bldg., Royal Oak
Calhoun, Ethel T.....707 Lakeview Ave., Birmingham
Calkins, Edwin A. (A).....865 N. Lapeer Rd., Lake Orion
Campbell, K. N.....1465 Cedar Bend Dr., Bloomfield Hills
Campbell, Malcolm D. (R).....(Address Unknown)
Capetanakis, D.....3613 Devonshire, Detroit 24
Carlisle, Jos. D.....1810 Woodward Ave., Birmingham
Carpenter, G. B., Jr.....622 N. Woodward, Birmingham
Carrow, Joyce M. (A).....1469 Highmoor Highway, Bloomfield Hills
Cefai, Anthony F.....35 S. Johnson, Pontiac
Chandler, Douglas.....1890 Southfield Rd., Birmingham
Chandler, Jos. H.....1401 S. Washington, Royal Oak
Cheng, James T. (A).....39 McKay Ave., E. Orange, N. J.
Cherup, Nicholas.....Pontiac General Hosp., Pontiac
Childers, Merle A.....320 Walnut, Rochester
Christensen, Willis L.....109 W. Eleven Mile Rd., Royal Oak
Clair, Alvin H.....31815 Southfield Rd., Birmingham
Clarke, Harriet A.....130 Seminole, Pontiac
Cline, Alan L.....4299 Roseberry, Drayton Plains
Cobb, Thos. H.....880 Woodward Ave., Pontiac
Cohen, Jack J.....17226 Adrian Rd., Southfield
Cohen, Lewis.....26602 Dundee Rd., Huntington Woods
Collins, Edward F., Jr.....35 W. Huron St., Pontiac
Condon, Frank J.....2401 E. Fourth, Royal Oak
Conner, Edward D.....3856 S. Miller Way, Birmingham
Conrad, Cecil D.....3027 N. Woodward Ave., Royal Oak
Cooksey, Norton J.....801 S. Adams Rd., Birmingham
Cooley, Roy V.....318 S. Blvd. West, Pontiac
Cooper, Edmond L.....4200 N. Woodward Ave., Royal Oak
Cooper, Robt. J. (A).....5917 E. 4th St., Tucson, Ariz.
Cooper, Robt. S.....3027 N. Woodward Ave., Royal Oak
Corrigan, K. E., Ph.D. (A).....Wm. Beaumont Hospital, Royal Oak
Coskey, Ralph J.....22100 Coolidge, Oak Park
Coucke, Henry O.....1148 S. Woowdard Ave., Royal Oak
Counts, Robert W.....302 Walnut St., Rochester
Crissman, Howell C.....22750 Woodward Ave., Ferndale 20
Crum, Roger E.....35 S. Johnson, Pontiac
Cudney, Ethan B. (L).....35 S. Johnson, Pontiac
Cutler, Wm. M.....800 S. Adams Rd., Birmingham
Dahlgren, Carl W.....3023 Orchard Lake, Keego Harbor
Darling, C. G., Jr.....880 Woodward Ave., Pontiac
Dayton, Richard C.....427 W. University Dr., Rochester
Dehne, Kurt G. (A).....Box A, Pontiac St. Hosp., Pontiac
Deighton, Murray N.....23023 Orchard Lake Rd., Farmington
De Jongh, Edwin.....Pontiac Motor Div., GMC, Pontiac
Delaney, Malcolm J.....23023 Orchard Lake Rd., Farmington
De Lawter, Hilbert H.....925 E. Maple Rd., Birmingham
Delevie, Jaap B.....640 Riker Bldg., Pontiac
Deutsch, Wm. L.....600 W. 11 Mile Rd., Royal Oak
De Vito, H. Louis.....3115 Angelus Dr., Pontiac
Dobski, Edwin J.....909 Woodward Ave., Pontiac
Doerr, Louis E., Jr.....1413 S. Washington, Royal Oak
Donnelly, Wm. J.....2561 Elizabeth Lake Rd., Pontiac
Dorsey, John M., Jr.....31815 Southfield Rd., Birmingham
Drew, Dale R.....909 Woodward Ave., Pontiac
Duane, William O...909 East 12 Mile Rd., Madison Heights
Duhamel, Peter A.....25000 W. Ten Mile Rd., Southfield
Dunlap, Gregg L.....2870 Orchard Lake Rd., Keego Harbor
Dunn, Lewis E.....3924 Twelve Mile Rd., Berkley
Durak, Gerald G.....1809 S. Main St., Pleasant Ridge
Durocher, Normand E.....35 S. Johnson, Pontiac
Dustin, Robt. W.....1314 W. Lincoln, Birmingham
Ekelund, Clifford T. (L).....35 W. Huron St., Pontiac
Elder, Edward E., Jr.....1116 Voorheis, Pontiac
Endress, Z. F., Jr.....35 S. Johnson, Pontiac
Engel, John B. (R).....235 Linden Rd., Birmingham
Ensroth, Jack F.....1100 N. Woodward, Birmingham
Esslinger, John O.....622 N. Woodward Ave., Birmingham
Evseeff, Geo. S.....2685 Amberly Rd., Birmingham
Farah, Jalil.....4385 Shenandoah, Allen Park
Fargher, Robert A.....660 South Boulevard E., Pontiac
Farnham, Lucius A. (L).....622 Riker Bldg., Pontiac
Fenton, James L. (A).....3241 Belle Court, Royal Oak
Fink, L. Jerome.....500 W. Huron St., Pontiac
Finkell, Lawrence J.....15231 W. Seven Mile Rd., Detroit 35
Fishman, Gordon R. A.....25721 Coolidge, Oak Park 37
Fitzpatrick, F. J.....92 Spokane Dr., Pontiac
Flaharty, Wm. J.....25000 W. Ten Mile Rd., Southfield
Flick, John R.....120 W. Second St., Royal Oak
Forest, Jean L.....4540 Pickering, Birmingham
Fox, Ralph M.....800 S. Adams Rd., Birmingham
Furlong, Harold A.....35 S. Johnson Ave., Pontiac
Fushman, John A.....4200 N. Woodward Ave., Royal Oak
Gaba, Howard B.....17328 Ohio, Detroit 21
Gaber, Ben.....10831 W. Ten Mile Rd., Oak Park 37
Gadbaw, Jos. J.....23607 Farmington Rd., Farmington
Gaensbauer, F.....1965 N. Hammond Lake Dr., Pontiac
Gagliardi, R. A.....880 Woodward Ave., Pontiac
Galpin, Richard R.....525 Southfield Rd., Birmingham
Garber, Max J.....23023 Orchard Lake Rd., Farmington
Gariepy, Bernard F.....120 W. 11 Mile Rd., Royal Oak
Gates, Edward M.....35 S. Johnson, Pontiac
Gates, Joann M.....861 W. Huron St., Pontiac
Gatley, Cleo R. (R).....97 N. Perry St., Pontiac
Gatley, Leslie W.....97 N. Perry St., Pontiac 14
Gause, Richard C.....31815 Southfield Rd., Birmingham
Gayles, Carlos B. (A).....51 Seminole St., Pontiac
Gehringer, Norman F.....880 Woodward, Pontiac
Geist, Edgar J., Jr.....1500 Walton Blvd., Rochester
Gell, James W.....35 S. Johnson Ave., Pontiac
Gelstein, Lazaro.....909 Woodward Ave., Pontiac
Gerls, Frank B. (L).....602 Pontiac Bank Bldg., Pontiac
Gibson, Wellington C.....206 E. Commerce, Milford
Gill, Matthew J.....3115 Franklin Rd., Bloomfield Hills
Glen, Harold.....26684 Grand River, Detroit
Goerner, Dorothy M. (A).....1500 Henrietta, Birmingham
Goldstein, Herbert.....22100 Coolidge Hwy., Oak Park 37
Goode, Norman J., Jr.....1117 S. Washington Ave., Royal Oak
Goodspeed, Roger F. (A).....2914 Griffith, Berkley
Gordon, Clayton H.....1099 N. Cranbrook Rd., Birmingham
Gradolph, Paul L.....23338 Woodward Ave., Ferndale 20
Gray, Murray H.....22100 Coolidge, Oak Park 37
Green, J. Donald.....217 Briggs Bldg., Birmingham
Green, Ralph S.....24100 Stratford, Oak Park 37
Green, Willard M.....35 S. Johnson, Pontiac
Grekin, Thos. D.....603 W. Eleven Mile Rd., Royal Oak
Gustafson, Everette.....35 S. Johnson, Pontiac
Gutterman, Meyer A.....25085 Coolidge Hwy, Oak Park 37
Haanes, Merle A.....909 Woodward Ave., Pontiac
Hackett, Danl. J.....782 Owego Dr., Pontiac
Hagman, George L. (L).....711 Rogue Valley Manor, Medford, Ore.
Hague, Gilbert W.....739 Westview Rd., Bloomfield Hills
Halsted, Lee H.....32440 Grand River Ave., Farmington
Hambalgo, George J.....3210 Belle Court, Royal Oak
Hamburger, Joel I.....20905 Greenfield Rd., Southfield
Hamilton, Quentin P.....20905 Greenfield, Southfield
Hammonds, Everett E. (A)....2851 Hyland Dr, Birmingham
Han, Maolin.....3358 Auburn Rd., Auburn Heights
Harmon, Lewis G.....1775 E. 14 Mile Rd., Birmingham
Harrold, John A.....534 Franklin Rd., Pontiac
Harvey, Campbell (L).....35 W. Huron St., Pontiac 15
Hassberger, John B.....620 N. Woodward Ave., Birmingham
Hathaway, Wm. S.....433½ Main, Rochester
Hayden, H. S., Ph.D. (A).....Wm. Beaumont Hospital, Royal Oak

Henderson, James E.....765 Oakleigh Dr., Bloomfield Hills
Henderson, Worth W.....1307 S. Washington, Royal Oak
Hendren, Owen S.....1408 Pontiac Bank Bldg., Pontiac 14
Henry, Colonel R.....125 W. Nine Mile Rd., Ferndale
Hensley, Chas. B.....248 S. Broadway, Lake Orion
Herman, Edward L.....Pontiac State Hosp., Pontiac
Hermes, Charles R..... 5790 M 15, Clarkston
Hoekman, Aben.....1740 Hamilton Dr., Rte. 3, Pontiac
Hopkins, Melvin, Jr.,.....900 Baldwin Ave., Pontiac 11
Hopkins, Wm. J.....17000 W. Eight Mile Rd., Southfield
Howell, Lynn E.....909 Woodward Ave., Pontiac
Hrushka, Myroslaw.....Pontiac State Hosp., Pontiac
Hsu, John J.....Pontiac State Hosp., Pontiac
Hubert, John R.....880 Woodward Ave., Pontiac 14
Ignatius, Aram A.....1915 E. Nine Mile Rd., Ferndale 20
Imperi, Lillian L.....13128 Wales, Huntington Woods
Jacobi, Rodman C.....91 S. Washington, Oxford
Jagnow, Nanette.....525 Southfield Rd., Birmingham
James, Robt. E., Jr.....2561 Elizabeth Lake Rd., Pontiac
Jenkins, Henry L.....161 State St., Pontiac
Johnson, Clare G.....909 S. Woodward Ave., Pontiac
Johnson, J. Frederic....23760 N. Woodward, Pleasant Ridge
Johnson, Robert H.....444 W. University Ave., Rochester
Joyce, John A.....413 Woodward Ave., Rochester
Jury, Donald B.....1126 S. Woodward Ave., Royal Oak
Kadian, George.....20905 Greenfield Rd., Southfield
Katz, Austin M. (A).....Pontiac State Hosp., Pontiac
Katz, Sidney F.....17350 Dorset, Southfield
Kaufman, Jacob M.....26075 Woodward Ave., Huntington Woods
Kay, Sherman A.....1026 S. Washington, Royal Oak
Kazdan, Louis L.....13801 W. Nine Mile Rd., Oak Park 37
Keeffe, Eugene J.....880 Woodward Ave., Pontiac
Kemp, Felix J.....880 Woodward Ave., Pontiac
Kendrick, H. F., Jr.....35 S. Johnson, Pontiac
Kennison, Warren S.....250 Martin, Birmingham
Kerr, Edwin C.....32749 Franklin Rd., Franklin
Ketchum, Jesse....26075 Woodward Ave., Huntington Woods
Kettler, Hans J.....25160 Edgemont Rd., Southfield
Klegman, Jerome H.....1700 W. Eight Mile Rd., Southfield
Klewicki, H. A.....22720 Woodward, Ferndale 20
Knox, Richard S.....325 Washington Sq. Pl., Royal Oak
Koehler, Wm. H.....4416 Far Hill Dr., Bloomfield Hills
Koltonow, Lawrence.....The Haven San., Rochester
Kornmesser, James G.....23023 Orchard Lake Rd., Farmington
Kozlow, Clifford S.....4274 N. Woodward, Royal Oak
Kozlow, L. Ange.....4274 N. Woodward, Royal Oak
Kozonis, Michael C.....880 Woodward Ave., Pontiac
Kozora, Elmer J.....17650 W. 12 Mile Rd., Southfield
Krane, Mark.....125 Alice Ave., Pontiac
Krecke, Charles F.....2250 Anderson S.E., Grand Rapids
Kresge, Bruce A.....1500 Walton Blvd., Rochester
Krieger, Norman N.....402 Union St., Milford
Krohn, Don R.....23023 Orchard Lake Rd., Farmington
Kuhel, Eli H.....24764 Southfield Rd., Southfield
Kuhn, Anne C.....4203 W. 13 Mile Rd., Royal Oak
Kuhn, Robt. E.....4203 W. 13 Mile Rd., Royal Oak
Kurnetz, Ruben.....10831 W. Ten Mile Rd., Oak Park
La Core, Ivan A.....Rice Memorial Clinic, Houghton
Ladd, James E.....21815 Southfield, Birmingham
Lahti, Paul T.....3600 W. 13 Mile Rd., Royal Oak
Lambert, Alvin G.....3027 N. Woodward, Royal Oak
Lambie, John S. (L).....280 Aspen Rd., Birmingham
Landry, Roy A.....Clarkston Prof. Center, Clarkston
Larson, Alvin R.....880 Woodward Ave., Pontiac
Laux, Philip J., Jr.....3027 N. Woodward, Royal Oak
Leach, Chas. A., Jr.....525 Southfield Rd., Birmingham
Leahy, Etta Link (R).....1616 Wiltshire, Berkley
Leichtman, R. R.....5770 Ortonville Rd., Clarkston
Lessien, Bruce T.....4045 W. Thirteen Mile, Royal Oak
Levin, Murray B.....7046 Cathedral Dr., Birmingham
Levine, Bernard....25835 Parkwood Dr., Huntington Woods
Lewis, Sol M. (L).....541 W. Oakridge, Ferndale
Lichtwardt, Harry E.....247 N. Hunter Blvd., Birmingham
Lichtwardt, John R.....247 N. Hunter Blvd., Birmingham
Lievois, Edward G.....289 Westbourne Dr., Birmingham
Lilly, Richard J.....6530 Cathedral Dr., Birmingham
Limia, Antonio G.....24360 Kenosha, Oak Park 37
Ling, T. W.....23607 Farmington Rd., Farmington
Linn, Herman J.....3601 W. 13 Mile Rd., Royal Oak
Longyear, Harold W.....4045 W. 13 Mile Rd., Royal Oak
Lowell, James W.....2330 Fairway, Birmingham
Lowery, Anthony J. (R).....8030 Flagstaff, Union Lake
Lussos, A. S.....2707 Bridle Rd., Bloomfield Hills
Lutes, Byron B.....1401 S. Washington Ave., Royal Oak
Lyons, Robt. T.....35 S. Johnson, Pontiac
Manz, Howard N.....23023 Orchard Lake Rd., Farmington
Marcotte, Oliver J.....25000 W. Ten Mile Rd., Southfield
Margrave, Edmund D. (L).....306 W. Ten Mile Rd., Royal Oak
Margulis, R. Ralph.....31815 Southfield, Birmingham
Markley, John M.....655 Ridge Rd., Bloomfield Hills
Maroko, Szymon W.....Pontiac State Hospital, Pontiac
Marra, John J.....461 W. Huron St., Pontiac
Marsa, Percy S.....785 N. Lapeer Rd., Lake Orion
Martin, Donald W.....Pontiac State Hosp., Pontiac
Martin, Francis A.....880 Woodward, Pontiac
Mason, Robt. J.....618 N Woodward Ave., Birmingham
Mathura, G. R.....880 Woodward Ave., Pontiac
Mayor, Raymond L.....35 S. Johnson, Pontiac
McCain, French H.....628 N. Woodward Ave., Birmingham
McCandliss, D. H.....35 S. Johnson, Pontiac
McConkie, James P.....2425 W. Lincoln, Birmingham
McDonald, Robert J.....4200 N. Woodward Ave., Royal Oak
McElroy, Wm. J., Jr.....420 East Fourth St., Royal Oak
McEvoy, Francis J.....1715 Crooks Rd., Royal Oak
McHugh, James M.....20905 Greenfield Rd., Southfield
McInerney, Thos. S.....2026 Laurome, Royal Oak
McIntyre, Jack B.....625 Purdy, Birmingham
McIntyre, Kenneth E. (A).....3830 Maule Rd., Pensacola, Fla.
McLaughlin, J. H.....604 N. Woodward, Birmingham
McNeill, Howard H.....225 W. Hickory Grove, Bloomfield Hills
McPhee, Edward C.....909 Woodward, Pontiac
McWhirter, W. W.....302 Walnut, Rochester
Mehas, Constantine P.....30404 Chickering Lane, Bloomfield Hills
Meisner, Harry E.....25497 Hereford, Huntington Woods
Mercer, Frank A. (L).....3032 Morningview Terr., Birmingham
Mevorah, Barukh L.....114 S. Lafayette, Royal Oak
Milgrom, Sidney.....1229 S. Washington St., Royal Oak
Miller, Arthur C.....17988 Buckingham, Birmingham
Miller, Hazen L.....31815 Southfield Rd., Birmingham
Miller, Hubert.....28554 Rivercrest, Southfield
Miller, Irving M.....23023 Orchard Lake Rd., Farmington
Miller, Sidney.....800 S. Adams, Birmingham
Mimura, James T.....31815 Southfield, Birmingham
Moloney, James C.....5851 Farmington Rd., Orchard Lake
Montgomery, J. C. (L).....25717 Coolidge, Oak Park 37
Morin, Leonard A.....29929 Vernon Dr., Southfield
Mueller, Elmer J.....31815 Southfiled Rd., Birmingham
Mumby, Clinton J.....26789 Woodward Ave., Huntington Woods
Munson, Harry L.....MacKenzie Clinic, Walled Lake
Murguz, Atalay M.....1625 E. Fourth St., Royal Oak
Nalbandian, Robt. M.....5154 Nob Hill Ct., Bloomfield Hills
Nalepa, Eugene J.....880 Woodward Ave., Pontiac
Nasizadeh, M. R. (A).....(Address Unknown)
Naz, John F. (A).....2826 Orange Grove, Waterford
Nessel, Jack H.....880 Woodward, Pontiac
Netzel, Robert J.....1376 Eason St., Pontiac
Newcomb, Arnold B.....19834 Riverside Dr., Birmingham
Nichamin, Samuel J.....20905 Greenfield Rd., Southfield
Nickerson, Ivey D.....6245 Golfview Dr., Birmingham
Niederluecke, D. C.....35 S. Johnson, Pontiac
Nosanchuk, Jos. I.....35 S. Johnson, Pontiac
O'Donnell, C. H.....23338 Woodward Ave., Ferndale 20
Oliphant, Wm. W.....785 N. Lapeer Rd., Lake Orion
Olsen, Richard E.....900 Woodward Ave., Pontiac
O'Neill, James A.....5790 M 15, Clarkston
Ormond, John K. (L).....909 Woodward Ave., Pontiac
O'Sullivan, Girardin S.....26520 Willowgreen Way, Franklin
Ott, Harold A.....3019 N. Woodward, Royal Oak
Overy, Donald C.....880 Woodward Ave., Pontiac
Packard, David C.....5648 Highland Rd., Pontiac
Page, Oliver W., Jr.....149 Franklin Blvd., Pontiac
Palmer, Hayden D.....35 W. Huron St., Pontiac
Patrick, Chas. I.....4721 Dixie Hwy., Drayton Plains

Patterson, J. C.....3600 W. Thirteen Mile, Royal Oak
Pauli, Theodore H.....880 Woodward Ave., Pontiac
Payton, Chas. F.....1719 Crooks Rd., Royal Oak
Pear, Erwin G.....3027 N. Woodward Ave., Royal Oak
Pearce, James F.....306 S. Washington Ave., Royal Oak
Peirce, Wm. H.....800 S. Adams Rd., Birmingham
Pelletier, Chas. J.....1111 N. Campbell, Royal Oak
Pensavecchia, J. S.....3235 Walma Drive, Orchard Lake
Pfister, Richard C. (A).....267 Elizabeth Lake Rd., Pontiac
Piggott, Leonard R.....(Address Unknown)
Pool, Robert, Jr.....1405 Pilgrim, Birmingham
Porter, Kenneth F.....2709 Bradway Blvd., Birmingham
Portnoy, Harold D.....445 W. Huron St., Pontiac
Ports, Preston W.....33108 Grand River, Farmington
Poznanski, Elva O.....26789 Woodward Ave., Huntington Woods
Poznanski, W. A.....1100 N. Woodward Ave., Birmingham
Prather, Frank W.....347 N. Main, Milford
Prendergast, J. J. (A).....1864 Fairview, Birmingham
Prevette, Isaac C. (L).....10 W. Huron St., Pontiac 14
Pridmore, John.....2741 Onagon Trail, Pontiac
Proctor, Bruce.....3431 Baldwin, Pontiac
Puhac, Maria (A).....Pontiac State Hosp., Pontiac
Quarton, Albert E., Jr.....542 Pilgrim Rd., Birmingham
Quigley, J. Patrick (A).....3229 Belle Court, Royal Oak
Quinn, James R., Jr.....2070 W. Valley Rd., Bloomfield Hills
Ragins, Abner I.....909 Woodward Ave., Pontiac
Ranney, Kenneth I.....1100 N. Woodward, Birmingham
Raszus, George C.....4680 Dixie Hwy., Drayton Plains
Raynale, George P. (L).....302 Wabeek Bldg., Birmingham
Read, James A.....610 N. Woodward, Birmingham
Rech, Wm. R.....MacKenzie Clinic, Walled Lake
Reeves, Elizabeth H.....7350 Cooley Lake Rd., Union Lake
Regualos, F. H., Jr. (A).....3601 W. 13 Mile Rd., Royal Oak
Reid, Fred T.....49 W. 14 Mile Rd., Clawson
Reid, Robert E.....2958 Woodslee, Royal Oak
Reilly, Richard C.....880 Woodward Ave., Pontiac
Reutter, Carolyn.....17600 Northland Pk. Ct., Southfield
Richard, Robert E.....1719 Crooks Rd., Royal Oak
Richards, Wilson P.....3500 W. Maple Rd., Birmingham
Richardson, Robt. P.....25717 Coolidge, Oak Park 37
Riggs, Harry L.....149 Franklin Blvd., Pontiac
Riker, Aaron D.....35 W. Huron St., Pontiac
Roehm, Harold R.....319 Wabeek Bldg., Birmingham
Rossin, Herbert W.....20905 Greenfield Rd., Southfield
Rowley, Laurie G. (L).....4400 Dixie Hwy., Drayton Plains
Rupp, Edson C., Jr.....1775 E. Fourteen Mile, Birmingham
Rush, Alva D., Jr.....391 Hamilton, Birmingham
Ruskin, David S.....20905 Greenfield Rd., Southfield
Russell, Vincent P.....324 Washington Sq. Bldg., Royal Oak
Rutzky, Julius.....St. Joseph Mercy Hosp., Pontiac
Ruva, Jos. J.....4463 Dixie Hwy., Drayton Plains
Sadovsky, Vincent J.....880 Woodward Ave., Pontiac
Safavian, M. H. (A).....900 Woodward Ave., Pontiac 19
St. John, Harold A.....35 West Huron St., Pontiac 15
Salisbury, C. S.....21580 Greenfield, Oak Park 37
Salva, Donald L.....32316 Grand River, Farmington
Samborski, Anne H.....32316 Grand River, Farmington
Sanford, Glenn A.....35 S. Johnson, Pontiac
Sansone, Thos. J.....909 Woodward Ave., Pontiac
Satersmoen, Theodore.....35 S. Johnson, Pontiac
Sawyer, Howard J. (A).....21971 Sloman, Oak Park 37
Schaefer, Wm. C.....240 Daines St., Birmingham
Schirle, Jos. L., Jr.....1116 Voorheis Rd., Pontiac
Schlecte, Eve L. (A).....609 Lake St., Tawas City
Schlelcte, I. Carl (A).....609 Lake St., Tawas City
Schmitt, Phillip E. (A)..... V. A. Hospital, Dearborn
Schneyer, Jerome J.....25000 W. Ten Mile Rd., Southfield
Schoenfeld, Robt. J.....794 N. Woodward Ave., Birmingham
Scholes, Danl. R.....277 Pierce St., Birmingham
Schorling Otis W.....302 Walnut, Rochester
Schuneman, Howard A.....23760 Woodward Ave., Pleasant Ridge
Schwartz, David.....33120 W. Twelve Mile, Farmington
Schweinsberg, Stephen.....1109 W. Long Lake Rd., Bloomfield Hills
Seaborn, Arthur J.....1413 S. Washington Ave., Royal Oak
Segula, Robt. L.....35 S. Johnson, Pontiac
Selman, Robert.....500 W. Huron St., Pontiac
Sempere, Chas. R.....35 S. Johnson, Pontiac
Sewell, Geo. R.....411 West Ten Mile Rd., Pleasant Ridge
Shadley, Maxwell L.....94 Ottawa Dr., Pontiac
Shea, James Joseph.....35 S. Johnson, Pontiac
Sheffield, Loren C.....35 S. Johnson, Pontiac
Sheridan, F. Michael.....1307 S. Washington St., Royal Oak
Sherkat, Mehdi (A).....Wm. Beaumont Hospital, Royal Oak
Siegel, Marvin D.....445 W. Huron St., Pontiac
Siffring, Loren W.....427 W. University, Rochester
Silvani, John.....909 Woodward Ave., Pontiac
Simpson, David F.....381 Rivard Blvd., Grosse Pointe 30
Simpson, Edward K. (L).....2 Sunset Avenue, Chatham, Ont., Canada
Simpson, John R.....800 S. Adams, Birmingham
Smith, Carleton A.....880 Woodward Ave., Pontiac
Smith, Donald S.....936 Riker Bldg., Pontiac
Smith, Geo. E.....629 Washington Sq. Bldg., Royal Oak
Somerville, Wm. J.....145 Cambridge, Pleasant Ridge
Sosin, Allen.....23023 Farmington Rd., Farmington
Spademan, Loren C.....484 Warren Court, Birmingham
Sencer, Lloyd H.....1219 S. Washington Ave., Royal Oak
Spoehr, Eugene L.....22832 Woodward Ave., Ferndale 20
Spohn, Earle W.....201 S. Center St., Royal Oak
Stageman, John C.....909 Woodward, Pontiac
Stanisavljevic, S.....2338 Woodward Ave., Royal Oak
Stanley, Wm. F.....1148 S. Woodward, Royal Oak
Steffes, Everette M.....3345 Coolidge Hwy., Berkley
Stolpman, A. K.....640 N. Woodward, Birmingham
Stratton, Donald P.....3601 W. 13 Mile Rd., Royal Oak
Stremler, Bernard J.....1460 Chesterfield, Birmingham
Stuecheli, Milton B.....1084 Willow Lane, Birmingham
Sullivan, Paul M.....909 Woodward Ave., Pontiac
Sutton, Palmer E.....222 Linden, Birmingham
Swickle, Edward F.....17 S. Main, Clawson
Swingle, Norman E.....2075 E. 14 Mile Rd., Birmingham
Szappanyos, Bela.....3325 Burning Bush Rd., Birmingham
Szybko, Valentine.....4274 N. Woodward, Royal Oak
Tarpinian, Dick A.....24601 Coolidge Hwy., Oak Park
Tauber, Abraham.....500 W. Huron St., Pontiac
Teshima, John Y.....22720 Woodward Ave., Ferndale 20
Tierney, Thomas D.....450 N. Woodward, Birmingham
Torgerson, Thos. S.....794 N. Woodward Ave., Birmingham
Touma, Alfred.....26789 Woodward Ave., Huntington Woods
Tregenza, Wm. K.....20905 Greenfield, Southfield
Trumpour, Donald J.....114 W. University Dr., Rochester
Ulgenalp, Attila O.....880 Woodward Ave., Pontiac
Ulveling, Robert A.....500 W. Huron St., Pontiac
Urwiller, K. L.....909 Woodward Ave., Pontiac
Van De Leuv, John H.....91 S. Washington St., Oxford
Vanden Berg, Kenneth.....35 S. Johnson, Pontiac
Van Zoeren, Jay J.....937 Rock Spring Rd., Birmingham
Varbedian, Thos. G.....205 Wabeek Bldg., Birmingham
Vaught, Richard K.....2009 Crooks Rd., Royal Oak
Victoria, M. A. (A).....108 Auburn, Pontiac
Virga, Geo. M.....715 N. Main St., Royal Oak
von Valtier, Cheryl C.....202 Walnut, Rochester
von Valtier, Wm. F.....202 Walnut, Rochester
Voss, Erich P. (A).....Pontiac State Hosp., Pontiac
Wagner, Ruth E. (L).....315 Ellen Ave., Royal Oak
Wake, Douglas L.....1406 Woodsboro, Royal Oak
Wallace, Donald B.....880 Woodward Ave., Pontiac
Wallack, Erwin N.....15660 W. Ten Mile Rd., Southfield
Wangner, William F.....1401 S. Washington, Royal Oak
Ward, W. Paul.....6631 Castle Drive, Birmingham
Warner, Fredk. O.....3245 Sashabaw Rd., Drayton Plains
Watson, Robert M.....402 Union St., Milford
Watson, Thos. Y.....640 N. Woodward, Birmingham
Weaver, Arthur (A).....91 Depot Line, Karachi, West Pakistan
Webber, Lynn F. (R).....461 Colonial Ct., Grosse Pte. 36
Wechsler, Norman.....880 Woodward Ave., Pontiac
Wegrzyn, George C.....2556 Endsleigh Dr., Birmingham
Weisman, Lawrence S.....909 East 12 Mile Rd., Madison Heights
Wendling, Dieter.....31815 Southfield Rd., Birmingham
Wessels, Robt. R.....302 Wabeek Bldg., Birmingham
Westfall, Edwin J.....1665 Twelve Mile Rd., Berkley
Westmaas, Wm. J.....364 Roanoke St., Birmingham
White, R. Hamilton.....384 Hamilton Ave., Birmingham
Wiant, John L.....258 Briggs Bldg., Birmingham
Wigent, Ralph D.....35 S. Johnson, Suite 26, Pontiac
Wilkinson, Wm. C.....880 Woodward Ave., Pontiac

Williams, John P.....35 S. Johnson, Pontiac
Willis, Maurice E.....35 S. Johnson, Pontiac
Woodward, Hanna L.....950 East Maple, Birmingham
Woodward, Robert D.....1100 N. Woodward Ave., Birmingham
Yesko, Veldora C.....26075 Woodward Ave., Huntington Woods
Ylvisaker, John R.....880 Woodward Ave., Pontiac
Young, Arthur R.....35 W. Huron St., Pontiac 15
Zimmerman, Walter J.....32340 Sylvan Lane, Birmingham
Zinterhofer, J. J., Jr.....27621 Santa Barbara Dr., Lathrup Village
Zujko, Alphonse J.....880 Woodward, Pontiac

OCEANA COUNTY MEDICAL SOCIETY (178)

Davis, Linford J.....22 N. State St., Hart
Diehl, Clarence E., Jr.....204 N. Michigan Ave., Shelby
Hasty, Willis A.....405 State St., Shelby
Johnson, C. A.....Box 6, New Era
Mullen, Warren R.....Pentwater
Ratzlaff, Alvin J.....219 State St., Hart
Robinson, Wm. G. (A).....Memorial Hospital, Fatehgarh, U. P., India
Vrbanac, John J.....22 N. State St., Hart
Wood, Merle G.....19 Courtland St., Hart

ONTONAGON COUNTY MEDICAL SOCIETY (182)

Archibald, Donald H.....Box 223, Ontonagon
Hogue, Harold B.....Ewen State Bank Bldg., Ewen
Lahti, Carl R.....800 Zinc St., Ontonagon
Pierpont, John.....White Pine
Strong, James P.....Ontonagon
Strong, Wm. F.....River St., Ontonagon

OTTAWA COUNTY MEDICAL SOCIETY (186)

Albers, Robt.....788 Columbia, Holland
Arendshorst, Wm.....121 W. 24 St., Holland
Balcer, Edwin A. (M).....1109 Cedar View Dr., Minneapolis, Minn.
Beernink, Ernest H.....408 Fulton St., Grand Haven
Bloemendaal, Dirk C.....351 N. Main St., Zeeland
Bloemendal, W. B.....224 Washington St., Grand Haven
Boersma, Vernon L.....121 W. 24 St., Holland
Bonzelaar, Alvin.....144 West 26th, Holland
Boone, Cornelius E. (L).....22 E. Central Ave., Zeeland
Bulthuis, Jerry E.....Jamestown
Chamness, James K.....121 W. 24th St., Holland
Clark, Nelson H.....17 W. 10 St., Holland
Cook, Carl S.....121 W. 24th St., Holland
DeVries, Harold G.....30 E. 9th St., Holland
DeVries, Peter J.....214 Washington St., Grand Haven
DeWitt, Donald E.....390 Fairhill Dr., Holland
DeYoung, Fredk. W.....Spring Lake
Dood, Arnold R.....598 Central Ave., Holland
Dykstra, Jerome H.....313 North River Ave., Holland
Endean, Donald H.....121 West 24th St., Holland
Frieswyk, Melvin J.....241 E. Main St., Zeeland
Groat, Frank L.....1624 Gladys, Grand Haven
Hager, Ralph.....Hudsonville
Hamelink, Marinus H.....700 W. 26th St., Holland
Harms, Herman P.....17 W. 10th St., Holland
Heard, Wm. (R).....504 Park St., Grand Haven
Hommerson, H. J.....Hamilton
Kearney, Jos. B.....121 W. 24 St., Holland
Kemme, Gerrit J.....Rte. 3, Zeeland
Kitchel, John H.....414 Franklin St., Grand Haven
Kitchel, Mary F. S.....414 Franklin St., Grand Haven
Kools, Wm. C.....194 W. 11th St., Holland
Korpi, Steven.....30 Clinton Ave., Grand Haven
Kuipers, Siebe W.....93 E. 29th, Holland
Leppink, Richard A.....121 W. 24th St., Holland
Long, Chas. E. (L).....222 Franklin St., Grand Haven
Mahaney, Robert C.....65 W. 22nd St., Holland
McArthur, Peter A.....414 Franklin, Grand Haven
Moerdyk, Wm. J.....120 W. 14th St., Holland
Nykamp, Russel R.....111 E. Main St., Zeeland
Post, J. Jay.....Allendale
Rottschaefer, Wm.....17 W. 10th St., Holland
Rypkema, Willard M.....22 S. 2nd St., Grand Haven
Schaftenaar, R. H.....86 E. 28th St., Holland
Smit, George J.....Holland
Smit, Henry (A).....c/o Dr. George Smit, 121 W. 24th St., Holland
Stobbelaar, Robt. H.....107 S. Second, Grand Haven
Ten Have, Ralph.....1030 Orchard, Grand Haven
Ten Pas, Henry W.....293 W. 29th St., Holland
Timmerman, Eugene C.....Coopersville
Van Appledorn, C. J.....99 W. 23rd St., Holland
Vander Berg, Edwin E.....17 W. 10th St., Holland
Van Der Velde, Otto.....33 W. 8th St., Holland
Vande Waa, Alfred J.....152 E. Cherry St., Zeeland
Van Kolken, P. J.....American Hospital, Pago Pago, Amer. Samoa
Veenstra, Bernard M.....Grand Haven
Ver Duin, John W.....223 Washington St., Grand Haven
Verkaik, Peter.....Hudsonville
Wells, Kenneth N.....119 W. Savidge S., Spring Lake
Westrate, Warren K.....17 W. 10th St., Holland
Westrate, Wm., Jr.....17 W. 10th St., Holland
Westrate. Wm., Sr. (L).....17 W. 10th St., Holland
Winter, John K.....726 State St., Holland
Winter, Wm. G., Jr.....630 State St., Holland
Yff, John H.....430 W. Lawrence, Zeeland
Yonkman, Fredk. F.....58 Pomeroy Rd., Madison, N. J.

SAGINAW COUNTY MEDICAL SOCIETY (190)

Ackerman, Gerald L.....124 S. Jefferson Ave., Saginaw
Albers, Millard J.....1227 N. Michigan Ave., Saginaw
App, Robt. G.....3422 Davenport, Saginaw
Averill, Walter C.....2110 Morson, Saginaw
Bagley, Ulysses S. (R).....1401½ N. Sixth St., Saginaw
Balcueua, Edgar P.....2 Chippewa Ct., Saginaw
Barry, Jack L.....5670 Dixie Hwy, Saginaw
Barry, Leroy C.....1500 Weiss St., Saginaw
Bass, Vernon V.....3322 Davenport, Saginaw
Behme, C. Peter.....1842 Glendale, Saginaw
Bertrand, Marc G.....1311 N. Michigan Ave., Saginaw
Bishop, Harry M.....705 Adams, Saginaw
Bow, William A.....4987 State St., Saginaw
Brender, Friedrich P.....Frankenmuth
Bruggers, Laurence.....1703 N. Michigan Ave., Saginaw
Bucklin, Robt. V.....Harris Co. Court House, Houston 2, Texas
Buechle, George J.....101 Marcy, St. Charles
Bullington, Bert M.....2000 Court St., Saginaw
Burnett, Quinter M.....4385 Concord, Saginaw
Busch, Frank J.....1731 N. Michigan St., Saginaw
Butler, Milton G.....502 S. Jefferson Ave., Saginaw
Cady, Donald J.....2002 Court St., Saginaw
Cady, Fredk. J., Jr.....402 S. Jefferson Ave., Saginaw
Cady, Fredk. J.....402 S. Jefferson Ave., Saginaw
Cameron, Allan K.....1314 S. Jefferson Ave., Saginaw

Campbell, Lloyd A. (R).....335 Brockway Pl., Saginaw
Caumartin, Hugh T.....1537 S. Washington Ave., Saginaw
Chisena, Peter R.....6221 Dixie, Bridgeport
Choate, Frances S.....1600 N. Michigan, Saginaw
Claytor, Archer A. (L).....603 N. 3rd Ave., Saginaw
Cortopassi, Andre J.....326 S. Washingotn Ave., Saginaw
Cortopassi, Vital E.....324 S. Washington Ave., Saginaw
Cory, Chas. W.....1227 N. Michigan, Saginaw
Cresswell, T. A.....1236 N. Michigan, Saginaw
Cullen, Geo. (A).....2529 N. Clinton St., Saginaw
Curts, James H.....1205 N. Michigan Ave., Saginaw
Davenport, Clyde P.....2110 Morson, Saginaw
Derifield, R. S. (A).....25 Bretton Ct., Saginaw
DeYoung, William A.....537 Millard St., Saginaw
Dowidat, Raymond W. (A).....608 Westfield, Saginaw
Durman, Donald C.....1600 N. Michigan Ave., Saginaw
Elder, Thomas R.....1609 N. Center Rd., Saginaw
Ely, Cecil W.....1820 James Ave., Saginaw
Ernst, Arthur R. (R).....Fieldmont, The Plains, Va.
Farley, Albert W.....1803 N. Michigan Ave., Saginaw
Field, E. Malcolm.....1803 N. Michigan Ave., Saginaw
Fleschner, Thos. E.....Birch Run
Galsterer, Edwin C.....128 S. Jefferson Ave., Saginaw
Gamon, Adam E., II.....2004 Court St., Saginaw
Gardner, Joe H.....815 N. Michigan Ave., Saginaw
Gerard, Roy J.....2419 Mackinaw, Saginaw
Gilmore, Robt. D.....234 W. Saginaw, Merrill
Goldner, Richard D.....1024 N. Michigan, Saginaw
Gomon, Louis D.....1203 N. Michigan Ave., Saginaw
Goodsell, John O.....1600 N. Michigan, Saginaw
Goodsell, J. Orton, D.D.S. (A).....1607 Cedar St., Saginaw
Goodwin, J. E.....515 S. Jefferson, Saginaw
Grigg, Arthur P.....320 N. Michigan Ave., Saginaw W. S.
Hand, Eugene A.....126 N. Franklin St., Saginaw
Harvie, Lloyd C. (L).....330 S. Washington Ave., Saginaw
Heavenrich, Robt. M.....1107 Gratiot Ave., Saginaw
Heilbronn, Duane B.....1703 N. Michigan, Saginaw
Helmkamp, Herbert O.....333 S. Jefferson, Saginaw
Hereza, Valeriano D.....2125 Bay St., Saginaw
Hester, Eustace G.....2031 N. Michigan Ave., Saginaw
Hill, Victor L. (R).....Box 234, Saginaw
Hoban, Sean J.....1232 N. Michigan Ave., Saginaw
Hubinger, H. L., D.D.S. (A).....501 2nd Natl. Bank Bldg., Saginaw
Hyslop, Wm. T.....1610 Gratiot Ave., Saginaw
Iizuka, Reiichi.....49 Davis Dr., Saginaw
James, John W.....1021 W. Genesee St., Saginaw
Jardinico, Robert.....303 S. Grange, Saginaw
Jarvi, Rudolph M.....1107 Gratiot Ave., Saginaw
Johnstone, Kermit T.....Box 2272, S. Side P.O., Saginaw
Jordan, Leo A.....1524 E. Genesee St., Saginaw
Kerr, Wm. B.....300 S. Michigan St., Saginaw
Keyes, James T.....10222 Maple Rd., Birch Run
Kickham, Edward F.....705 Adams St., Saginaw
Kleekamp, Herbert G.....1005 Gratiot Ave., Saginaw
Kleinschmidt, Earl E.....3625 Webber St., Saginaw
Kolesar, Robt. C.....1005 Gratiot, Saginaw
Kowals, Francis V.....Med. Dir., Chec. Ser., GMC, Saginaw
Kretschmer, Thos. V.....1232 N. Michigan Ave., Saginaw
Lassignal, Jules C.....2125 Bay St., Saginaw
Ling, Kenneth C.....Hemlock
Lohr, Oliver W.....614 Madison, Saginaw
Lohr, Thos. O.....1135 N. Michigan Ave., Saginaw
Love, Neil W.....505 W. Tuscola, Frankenmuth
Lurie, Robt. I.....2525 S. Washington Ave., Saginaw
Mahaney, Thos. P.....3521 State St., Saginaw
Manning, John E.....815 N. Michigan Ave., Saginaw
Manning, John W., III.....705 Adams, Saginaw
Markey, Francis L.....808 N. Michigan Ave., Saginaw
Martzowka, Wm. P.....415 W. Genesee St., Saginaw
Mason, Wm. G.....1107 Gratiot Ave., Saginaw
Matthews, Harry C.....1227 N. Michigan Ave., Saginaw
Maurer, John.....1109 Elmdale, Saginaw
Mayne, Harold E.....2111 Marshall Ct., Saginaw
McEwen, Wm. G.....820 Orchard Court, Saginaw
McKinney, A. R. (L).....1403 Howard, Saginaw
Meyer, Henry J. (L).....6243 Dixie Hwy., Bridgeport
Mikan, V. Robert.....3900 Holland Dr., Saginaw
Miller, Glenn F.....2224 Mershon, Saginaw
Moon, A. Raymond (L).....1008 Hancock, Saginaw
Morgrette, Leonard J.....3424 Davenport, Saginaw
Mudd, Richard D.....Chev. Grey Foundry, Saginaw
Murphy, Albert P.....303 N. Michigan Ave., Saginaw
Murphy, Richard T., D.D.S. (A).....1718 N. Michigan, Saginaw
Murray, Morris J.....3424 Davenport, Saginaw
Nelson, Oscar A.....3324 Davenport, Saginaw
Nelson, Robert E. (A).....1500 Weiss St., Saginaw
Noble, Paul R.....1447 N. Harrison, Saginaw
Northway, Robt. O.....124 S. Jefferson Ave., Saginaw
Novy, Frank O.....420 S. Jefferson Ave., Saginaw
Olson, Carl P. (A).....122 Morningside Dr., Battle Creek
Phillips, Homer A.....124 S. Jefferson Ave., Saginaw
Pietz, Fredk.....221 N. Michigan Ave., Saginaw
Powers, Robt. F.....1600 N. Michigan, Saginaw
Prather, Perry E.....1227 N. Michigan Ave., Saginaw
Prinsell, Gustave G. (M).....P.O. Box 33, Sierra Leone, W. Africa
Rank, J. Eugene.....1107 Gratiot Ave., Saginaw
Reimers, Gerald F.....4046 Hess St., Saginaw
Rice, William T.....1827 N. Michigan Ave., Saginaw
Richards, Ned W.....3518 State St., Saginaw
Richter, Harry J.....705 Adams St., Saginaw
Roggen, Ivan J.....1227 N. Michigan, Saginaw
Ruskin, Dave B.....120 N. Michigan Ave., Saginaw
Ryan, Richard S.....1315 S. Washington Ave., Saginaw
Sample, John T. (L).....602 Rust St., Saginaw
Sargent, Donald V.....1703 N. Michigan Ave., Saginaw
Schneider, A. J. N.....509 S. Jefferson Ave., Saginaw
Schultz, Frank R.....147 W. Broad St., Chesaning
Sharp, Martin C.....1803 N. Michigan Ave., Saginaw
Shek, John L.....808 N. Michigan Ave., Saginaw
Sheldon, Suel A.....124 S. Jefferson, Saginaw
Sherman, John W.....403 S. Fayette, Saginaw
Skowronski, C. A.....1401 E. Genesee St., Saginaw
Slade, Homer G.....1520 N. Michigan Ave., Saginaw
Spengler, Donald E., D.D.S. (A).....4481 Bradford Dr., Saginaw
Stander, Aaron C.....1411 Court St., Saginaw
Stewart, Geo. W.....1902 Janes St., Saginaw
Sulfridge, Hugh L., Jr.....512 N. Michigan Ave., Saginaw
Thompson, Arthur B.....2144 Ottawa St., Saginaw
Tiedke, Gunther E.....120 N. Michigan Ave., Saginaw
Toshach, Clarence E.....3655 Schust Rd., Saginaw
Toteff, Robert J.....2110 Morson, Saginaw
Tramitz, Melvin E.....4850 Henry Dr., Saginaw
Underhill, Wm. G.....1801 Zauel, Saginaw
Vincent, John H.....1911 Seminole Lane, Saginaw
Vitu, Robert L.....703 W. Genesee, Saginaw
Volk, Vladimir K.....Saginaw Co. Hosp., Box 65, Saginaw
Waite, Barry F.....403 S. Fayette, Saginaw
Webb, Walter L.....1502 Wadsworth, Saginaw
Weiss, Arno W.....3521 State St., Saginaw
Westlund, Norman.....3253 Congress, Saginaw
Woomer, Donald F.....1227 N. Michigan Ave., Saginaw
Wright, Edwin M.....1311 N. Michigan, Saginaw
Yntema, Stuart.....331 S. Jefferson Ave., Saginaw

ST. CLAIR COUNTY MEDICAL SOCIETY (194)

Bailey, Robt. S.....2425 Military St., Port Huron
Banting, Kenneth C.....403 Peoples Bank Bldg., Port Huron
Barss, J. A.....1209 Tenth St., Port Huron
Battley, John C. S.....1216 6th St., Port Huron
Beck, Frank K.....2902 Military, Port Huron
Beer, Jos F.....104 N. Riverside Ave., Saint Clair
Bennett, Wm. G.....210 S. Main St., Yale
Borden, Chas. L.....313½ Huron, Port Huron
Bottomley, Thos. H., Jr.....1102 Sixth St., Port Huron
Boughner, Walter H.....325 Pleasant St., Algonac
Bovee, Marion E. (L).....2208 Stone St., Port Huron
Bowden, Wm. S.....130 Washington, Marine City
Bridge, Ezra V.....416 Edison Blvd., Port Huron
Brush, Howard O. (L).....3233 Elk, Port Huron
Burke, Colman J.....411 Andrew Murphy Dr., Port Huron
Cantwell, John D., Jr.....2425 Military, Port Huron

Carrie, Robt. G. (A).....837 Marconi, Montebello, Calif.
Chafty, Mahmoud.....2425 Military, Port Huron
Cleland, Wm. D., Jr.....Medical Arts Bldg., Port Huron
Clifford, Robt. P.....506 S. Riverside Dr., St. Clair
Clyne, Benj. C.....103 N. Main St., Yale
Coury, John J., Jr.....1209 Tenth St., Port Huron
Davison, Wm. T.....2425 Military St., Port Huron
Dinnen, Wm. J., Jr.....2425 Military, Port Huron
Douvas, Nicholas G.....311 Pine St., Port Huron
Dupuis, Jean Paul.....4251 Peck Rd., Port Huron
Fitzgerald, E. W., Jr.....1102 Sixth St., Port Huron
Franke, Armin T.....2425 Military, Port Huron
Fulton, Harold E., Jr.....2425 Military St., Port Huron
Gerrits, James F.....St. Clair Clinic, St. Clair
Gholz, Anthony C.....Medical Arts Bldg., Port Huron
Gilmore, John R.....317 Mich. Bank Bldg., Port Huron
Gonzalez, Carlos F.....1605 Division Rd., St. Clair
Hazledine, H. J.....4685 Lakeshore Rd., Port Huron
Holcomb, Russell J.....140 S. Market, Marine City
Johnston, Thomas C.....2425 Military St., Port Huron
Kahn, Oscar B.....Capac
Kesl, Geo. M. (L).....1311 Scott, Port Huron
Kirban, Harry N.....5500 Lakeshore Rd., Port Huron
Kirker, Findlay O.....1325 Michigan Ave., Marysville
Koch, Donald A.....2425 Military St., Port Huron
Kostoff, Harold R.....310 Water St., Port Huron
Lauridsen, James.....621 River St., Port Huron
LeGalley, K. B.....Awali, Bahrain, Persian Gulf
Licker, Reuben R.....2425 Military St., Port Huron
Ludwig, Claude A.....916 Seventh St., Port Huron
Ludwig, Fredk. E.....916 7th St., Port Huron
Lugg, Robt. M.....619 River St., Port Huron
MacPherson, C. A. (R)....401 Country Lane, Louisville, Ky.
Mayhew, Harry E.....8199 S. Riverside, Marine City
McColl, Duncan J. (L).....917 Prospect Place, Port Huron
Meza, Pedro.....902 Tenth, Port Huron
Miller, John M.....1010 Griswold St., Port Huron
Mohney, Glenn E.....311 Pine St., Port Huron
Morris, Alvin N.....621 River St., Port Huron
Novak, Walter S.....310 E. Water St., Port Huron
Patterson, Dorsey W. (L).....622 Huron Ave., Port Huron
Pollock, Donald A. (A).....5014 Lakeshore, Port Huron
Raftery, Michael.....2425 Military, Port Huron
Rowe, Robt. E.....3360 W. Water St., Port Huron
Sanderson, Jos. L.....515 Pine St., Port Huron
Sands, Geo. E. (L).....3227 Gratiot Ave., Port Huron
Schaefer, Waldo A.....302 Mich. Bank Bldg., Port Huron
Selby, Clarence D.....1916 Military St., Port Huron
Serniak, John A.....104 S. Main St., Yale
Shoudy, Elmore D.....902 Tenth Ave., Port Huron
Sites, Edgar C.....1209 Tenth St., Port Huron
Snider, James J.....2425 Military, Port Huron
Tisdel, James H.....310 E. Water St., Port Huron
Tomsu, Glenn F.....310 E. Water St., Port Huron
Townley, Chas. O.....1209 Tenth St., Port Huron
Ulmer, Arthur H., Jr.....1209 Tenth St., Port Huron
Walker, Sidney C.....1209 Tenth St., Port Huron
Ware, J. Raleigh.....3107 24th St., Port Huron
Wass, Henry C.....115 Adams, St. Clair
Weckesser, W. C.....1602 Military, Port Huron
West, Roger F.....619 River St., Port Huron
Yost, Kenneth W.....1305 Gratiot Ave., Marysville
Youngs, John A.....718 Griswold St., Port Huron
Yull, Arthur B.....1209 Tenth St., Port Huron

ST. JOSEPH COUNTY MEDICAL SOCIETY (198)

Berg, Lawrence A.....106 E. Chicago Rd., Sturgis
Bradley, D. E.....234 S. Main St., Colon
Braham, Wilbur G.....111 S. Monroe, Sturgis
Brothers, Paul L.....104 S. Lakeview, Sturgis
Brunson, Allen E.....206 E. West St., Sturgis
Dettman, Harold.....Maplecrest Plaza, Sturgis
Evans, Robt. H.....111 S. Monroe St., Sturgis
Fiegel, S. Albert.....111 S. Monroe, Sturgis
Fortner, Roscoe J.....137 Portage Ave., Three Rivers
Gillespie, Eleanor M.....R. 2, Sturgis
Hill, Robert V.....117 Spring St., Three Rivers
Jacobowitz, John M.....Lincoln at Millard, Three Rivers
Lepard, Olin L.....Knollwood Dr., R. 1, Sturgis
Miller, Chas. G. (L).....106 W. Chicago St., Sturgis
O'Dell, Charles W.....117 Spring St., Three Rivers
Olney, Frank.....Centerville
Olney, Harold E.....Leonidas
Pennington, Harry C.....118 S. Kalamazoo, White Pigeon
Penzotti, Stanley C.....117 Spring St., Three Rivers
Porter, Clark G.....226 East St., Three Rivers
Schimnoski, D. R.....Three Rivers Med. Clnc., Three Rivers
Shaw, Geo. D.....117 Spring St., Three Rivers
Sheldon, John P.....206 E. West St., Sturgis
Smith, Robt. D.....Colon
Springer, Russell A. (R).....R. 2, Sturgis
Storer, William R.....St. Jos. Co. Health Dept., Centerville
Weisheit, H. R.....Route 1, Sturgis
Zimont, Chas. R.....Constantine
Zimont, Raymond D.....Constantine

SANILAC COUNTY MEDICAL SOCIETY (202)

Cripps, James R.....Marlette
Duvall, Dorothy V.....817 Patterson Ave., Bay City
Ford, Frances A.....2683 S. Lakeshore Rd., Applegate
Gift, Weldon A.....Marlette
Groat, Gerald.....Deckerville
Hart, Robt. K.....Croswell
Jayson, Michael H.....2764 Lorraine St., Marlette
McCrea, John W.....Marlette
McGunegle, Keate T.....Sandusky
Muir, Neil.....Croswell
Seager, M. Cole.....Brown City
Smith, Duane E.....Brown City
Tweedie, G. Evans.....Sandusky
Tweedie, S. Martin.....Sandusky
Webster, J. C. (L).....Marlette
Winfield, Raymond J.....3014 Main St., Marlette

SHIAWASSEE COUNTY MEDICAL SOCIETY (206)

Arnold, Alfred L., Jr. (L).....R. 1, Ovid
Austin, Eugene S.....1260 Ada St., Owosso
Bach, Norman F.....113 E. Williams, Owosso
Bjarnesen, Walter.....Durand Medical Clinic, Durand
Brown, Richard C.....113 E. Williams St., Owosso
Brown, Richard J. (R).....9230 Cedar Knoll Dr., Grass Lake
Buzzard, Walter D.....Chesaning
Chipman, Elwood M. (R).....502 W. Williams St., Owosso
Clifford, Robert.....Matthews Bldg., Owosso
Foerster, Alfred W.....113 E. Williams St., Owosso
Ford, Wm. J. A., Jr.,.....113 E. Williams St., Owosso
Forsyth, Henry T.....Chesaning
Graves, James H.....511 W. Main St., Owosso
Gurden, Elizabeth A. L.....113 E. Williams St., Owosso
Harroun, John E.....105 N. Water St., Owosso
Harroun, R. V.....Matthews Building Owosso
Hofstra, John .....Owosso
Hoshal, Verne L.....104 W. Clinton, Durand
Kennedy, John J.....1626 N. Chipman, Owosso

Lieber, Robt. W.....103 E. Clinton St., Durand
MacGregor, John F.....113 E. Williams St., Owosso
McKnight, Edwin R.....320 N. Washinton St., Owosso
Merz, Walter L.....307 N Ball, Owosso
Moore Phillip J.....221 E. North St., Owosso
Morin, Richard.....Durand
Park, James H.....812 Bradley St., Owosso
Phillips, Rolland.....Matthews Bldg., Owosso
Richards, Chester J.....213 Mercer, Durand
Rotv, Robert L.....406 N. Saginaw St., Durand
Sahlmark, Jos. F.....812 Bradley St., Owosso
Sauer, Peter.....113 E. Williams, Owosso
Shepherd, Walter F. (R).....921 Coolidge Rd., Lansing 12
Trick, O. L.....Durand
Weinkauf, Wm. F.....Corunna
Weston, Claude L.....Matthews Bldg., Owosso
Wickstrom, Geo. B.....529 Clarke Ave., Owosso

TUSCOLA COUNTY MEDICAL SOCIETY (210)

Ballard, James H.....Cass City
Chapin, Maurice H.....Millington
Cole, Versa V.....Lock Box A, Caro
Dickerson, Willard W.....Caro State Hosp., Caro
Donahoe, Harold T.....Pleasant Home Hosp., Cass City
Elmendorf, E. N., II.....Vassar
Flett, Richard O.....Millington
Gugino, George J.....1941 Gate St., Reese
Howlett, Robt. R.....624 W. Frank St., Caro
Merrill, Elmer H.....506 Gilfad Rd., Caro
Miles, Edward J.....Caro
Nigg, Herbert L.....Caro
Savage, Lloyd L.....147 W. Lincoln, Caro
Swanson, Ewald C.....220 N. Main, Vassar
Von Renner, Otto (L).....837 W. Huron St., Vassar

VAN BUREN COUNTY MEDICAL SOCIETY (214)

Boothby, Carl F.....Hartford
Boothby, Fredk. M.....Lawrence
Boothby, Paul.....Lawrence
Bope, Wm. P. (L).....Decatur
Cooper, Jos. E.....417 W. Monroe St., Bangor
Davis, James M.....311 Center St., South Haven
Diephuis, Bert.....511 Huron St., South Haven
Dillon, Thos. J.....R.F.D. 3, Paw Paw
Gano, Avison.....417 Monroe St., Bangor
Groustra, Glenn R.....511 Huron St., South Haven
Itzen, John F.....P.O. Box 128, South Haven
Johnson, Harold C. A.....Upjohn Co., 320 Portage, Kalamazoo
Kleber, John A.....311 Center St., South Haven
Lawther, John.....P.O. Box 191, Hartford
Loomis, Frank J.....Paw Paw
McManus, T. M.....305 E. Oak St., Paw Paw
Millard, David.....Paw Paw
Morgan, Dale K.....403 Phoenix St., South Haven
Parks, Arthur E.....Lawton
Spalding, R. W.....Box 187, Bloomingdale
Stagg, Adelbert L.....9 N. Maple St., Hartford
Stagg, G. Lee.....Box 307, Hartford
Stagg, Ruth E. A.....Box 38, Hartford
Steele, Arthur H.....Paw Paw
Sundin, Paul W.....Decatur
Ten Houten, Charles.....Paw Paw
Terwilliger, Edwin H.....P.O. Box 110, South Haven
Urist, Martin J.....R.D. 1, South Haven
Young, Wm. R. (L).....Lawton

WASHTENAW COUNTY MEDICAL SOCIETY (218)

Alford, Barry H.....385 N. Mill, Plymouth
Allen, Arthur W.....5 Harvard Pl., Ann Arbor
Allen, Richard J.....University Hospital, Ann Arbor
Anderson, David G.....627 Westwood, Ann Arbor
Angell, David C.....1420 Hatcher Cresant, Ann Arbor
Atchison, Russell M.....501 W. Dunlap, Northville
Badgley, Carl E. (L).....1313 E. Ann St., Ann Arbor
Bailey, Robt. W.....University Hosp., Ann Arbor
Baird, Walter M. (A).....2558 Old Boston Ct., Ann Arbor
Bandera, Emily A.....2800 Plymouth Rd., Ann Arbor
Banghart, Norman L.....1950 Manchester Rd., Ann Arbor
Barker, Paul S. (R).....Box 87, Bonnots Mill, Mo.
Barlow, R. Craig.....326 N. Ingalls St., Ann Arbor
Barnwell, John B. (R).....R.F.D. 2, Blairstown, N. J.
Barron, Walter L.....326 N. Ingalls, Ann Arbor
Barss, Wm. A.....525 W. Cross St., Ypsilanti
Bartholomew, Lee E.....4633 Kresge Bldg., U.M., Ann Arbor
Bass, Thos. J.....201 S. Hamilton, Ypsilanti
Bassow, Paul H.....St. Joseph Hosp., Ann Arbor
Bauer, Gerhard H.....2015 Manchester Rd., Ann Arbor
Bauer, Jere M.....1313 E. Ann St., Ann Arbor
Beckett, Morley B.....207 Fletcher Ave., Ann Arbor
Behrman, Saml.....1313 E. Ann St., Ann Arbor
Beierwaltes, Wm. H.....U.M. Medical Center, Ann Arbor
Beison, Richard A.....1900 W. Stadium Blvd., Ann Arbor
Beljan, John R. (A).....2320 N. Lockhart Ave., Sherman, Texas
Bell, Margaret (L).....1719 East Prince Rd., Tucson, Ariz.
Belser, Walter.....2310 E. Stadium Blvd., Ann Arbor
Bender, Leonard F.....1313 E. Ann St., Ann Arbor
Benson, Paul J., Jr.....221 N. Sheldon, Plymouth
Bentley, Fredk. E.....851 S. Main St., Plymouth
Berkley, Kelly M.....1606 Waltham Dr., Ann Arbor
Berry, Robert E. L.....University Hospital, Ann Arbor
Bicknell, John N.....703 First Natl. Bldg., Ann Arbor
Bicknell, Joseph M. (A).....97 Valhalla Dr., Ann Arbor
Bird, H. Waldo, Jr.....325 Barton Shore Dr., Ann Arbor
Bishop, Ronald C.....1011 Lincoln Ave., Ann Arbor
Boblitt, Delbert E.....St. Joseph Mercy Hosp., Ann Arbor
Boles, Roger (A).....4785 Lake Ct., Ann Arbor
Bosch, Jan K.....302 W. Main St., Northville
Botch, Edmund S.....2310 E. Stadium Blvd., Ann Arbor
Botsford, James H.....109 N. Main St., Chelsea
Bourne, Charles W. (A).....Univ. Hospital, Ann Arbor
Brandt, Ralph L.....326 N. Ingalls, Ann Arbor
Breakey, Barry A.....2216 Medford, Ann Arbor
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Anderson, Walter L.....1553 Woodward Ave., Detroit 26
Andreou, Byron.....460 Eastland Ctr., Harper Woods
Angel, John J.....34549 Main St., Wayne
Annessa, Domenico M. (L).....3536 Burns Ave., Detroit 14
Ansley, Mary K.....32718 Grand River, Farmington
Appelman, Howard B.....1553 Woodward Ave., Detroit 26
Arcari, Frederico A.....771 Fisher Bldg., Detroit 2
Archambault, Henry A. (A).....Jirapa, Gold Coast, Africa
Archambault, Rene F.....35550 Michigan Ave., Wayne
Arehart, Burke W.....11540 Morang Dr., Detroit 24
Aries, C. T.....10030 Cadieux Rd., Detroit 24
Arminski, Thos. C.....1066 Fisher Bldg., Detroit 2
Armstrong, Arthur G.....3001 W. Grand Blvd., Detroit 2

Armstrong, Mac. J.....15125 Grand River, Detroit 27
Arnkoff, Morris.....18241 Greenfield, Detroit 35
Arnold, Effie E. (L).....16520 Oakfield, Detroit 35
Arnold, Wm. J., Jr.....8203 12th St., Detroit 6
Arnoldi, Forrest J.....Harper Hospital, Detroit 1
Arrington, Robyn J.....7811 Oakland Ave., Detroit 11
Asa, Morris.....763 David Whitney Bldg., Detroit 26
Ascher, Meyer S.....1508 Dav. Brodwick Twr., Detroit 26
Ashe, Stilson R. (L).....8031 W. Vernor Hwy., Detroit 9
Ashley, Lowell B. (R).....5811 N.E. 21 Rd., Ft. Lauderdale, Fla.
Asselin, Regis F.....20480 Eastwood Dr., Detroit 36
Atler, Lawrence R.....681 W. Forest, Detroit 1
Auble, Max E.....2501 W. Grand Blvd., Detroit 8
August, Harry E.....26339 Woodward, Royal Oak
Austin, Donald C.....320 Professional Blvd., Detroit 1
Austin, Shirley.....5224 St. Antoine St., Detroit 2
Ausum, John D.....6420 Hartwell, Dearborn
Avrin, Ira.....10821 Puritan, Detroit 38
Axelrod, Arnold R.....15001 W. Eight Mile Rd., Detroit 35
Axelrod, Mildred A. (A).....13725 8 Mile Rd., Detroit 35
Axelrod, Robt. G. (A).....18518 Appoline, Detroit 35

Babcock, Lloyd K. (L)....16420 Schoolcraft Ave., Detroit 27
Babcock, Myra E.....7 Poplar Park, Pleasant Ridge
Babcock, Warren W. (R).....2661 Northeast Ninth, Pompano Beach, Fla.
Bach, Walter F. (L).....5419 Livernois Ave., Detroit 10
Bacher, Burton J.....1015 Kales Bldg., Detroit 26
Bachman, Morris E.....10326 W. 7 Mile Rd., Detroit 21
Bacon, Vinton A. (L).....18400 Livernois, Detroit 21
Bader, Benj. H.....2654 W. Grand Blvd., Detriot 2
Baeff, Michael A. (R).....15435 Stahelin Ave., Detroit 23
Baer, Geo. J.....1553 Woodward Ave., Detroit 26
Baer, Marga.....16321 Mack Ave., Detroit 24
Baer, Walter.....16321 Mack Ave., Detroit 24
Bagley, Harry E. (A).....7541 Oakman Blvd., Dearborn
Bahra, Robt. J.....20905 Greenfield, Southfield
Bailey, Louis J.....20905 Greenfield Rd., Southfield
Baima, Margaret A.....1212 David Whitney Bldg., Detroit 26
Baker, Clarence (L).....J16 Palmetto Trl. Pk., Palmetto, Fla.
Bakst, Joseph A. (L).....10 W. Warren, Detroit 1
Balaga, Frank T.....9701 Joseph Campau Ave., Hamtramck 12
Balberor, Harry.....275 W. Grand Blvd., Detroit 16
Balcerski, Matthew A.....10 Peterboro St., Detroit 1
Ballard, Donald R.....22231 W. Outer Dr., Dearborn
Balow, Ross M.....18700 Meyers Rd., Detroit 35
Balser, Chas. W. (L).....13931 Gratiot, Detroit 5
Banish, Gerald.....23100 Cherry Hill, Dearborn
Barak, Lewis R.....7448 W. Seven Mile Rd., Detroit 21
Barak, Stuart.....18241 Greenfield, Detroit 35
Baran, Alphonse W.....15841 W. Warren St., Detroit 28
Barbaglia, Louis C.....16378 Harper, Detroit 24
Barber, Radivoj R.....864 S. Main St., Plymouth
Bardenstein, M. B.....17000 W. 8 Mile Rd., Southfield
Barefield, Alwin S.....8629 W. Eight Mile Rd., Detroit 21
Barenholtz, Benj.....20905 Greenfield, Southfield
Barker, David H.....7220 Gratiot Ave., Detroit 13
Barland, Oscar (A).....8401 Woodward Ave., Detroit 2
Barlow, Myron.....18050 Mack, Grosse Pointe
Barnes, Van D. (R).....11040 Ingram, Livonia
Barnett, Louis L.....10 Witherell St., Detroit 26
Barnett, Morton.....1527 David Stott Bldg., Detroit 26
Barnhardt, R. A.....Ford Motor Co., Highland Park 3
Barone, C. Gerald.....15231 W. 7 Mile Rd., Detroit 35
Barrett, C. D., Jr.....316 City County Bldg., Detroit 26
Barrett, Raymond J.....18280 Fairfield, Detroit 21
Barrett, Wyman D. (L)....1553 Woodward Ave., Detroit 26
Barron, James.....2535 Amberly Rd., Birmingham
Barron, Wm. H.....14938 Livernois Detroit 38
Barsky, David.....100 Oak St., Wyandotte
Barton, Jos. R.....19619 W. Warren, Detroit 28
Baruch, Robert J.....18737 Hilton Rd., Southfield
Basel, Arthur R.....41001 Seven Mile Rd., Northville
Baskin. Sidney.....19207 Schaefer Rd., Detroit 35
Batchelor, Thomas M.....18060 Conant, Detroit 34
Bates, Gaylord S.....861 Monroe Blvd., Dearborn
Battle, John M.....6904 Charlesworth, Dearborn 6
Bauer, A. Robt.....19268 Grand River Ave., Detroit 23
Bauer, Benedict J.....16451 Schoolcraft, Detroit 27
Bauer, Lester E.....4 Woodside Pk., Pleasant Ridge
Bauer, Ralph E.....Henry Ford Hospital, Detroit 2
Bauer, Raymond B.....1326 St. Antoine St., Detroit 26
Baugh, Richard H.....24216 Michigan Ave., Dearborn
Baugh, Robert F.....17520 Chester, Detroit 24
Baumer, Moe.....10 Peterboro, Detroit 1
Baumgarten, Elden C. (L).....20867 Mack Ave., Grosse Pointe Woods 36
Baumgarten, Thos. W.....20867 Mack Ave., Grosse Pointe 36
Baxter, Seymour.....19925 Livernois, Detroit 21
Bayles, John G.....14359 Michigan, Dearborn
Bazil, Gilbert M.....14200 Puritan, Detroit
Beach, Watson.....20815 Mack Ave., Detroit 36
Beam, A. Duane....20160 Mack Ave., Grosse Pointe Woods
Beamer, Geo. D.....14853 Michigan Ave., Dearborn
Beard, James E.....23801 Fordson, Dearborn
Beck, Stanley M., Jr.....13118 Fort St., Wyandotte
Becker, Abraham.....10 Witherell St., Detroit 26
Beckett, Peter G. S.....951 E. Lafayette St., Detroit 7
Beckett, Victoria L. (A)....1420 Anita, Grosse Pointe Woods
Becklein, Clarence L.....14351 E. Warren Ave., Detroit 15
Beckman, Hugh.....20001 Greenfield, Detroit 35
Beckwith, Carl C.....3340 Fenkell, Detroit 38
Bedell, Archie A.....15545 Mack Ave., Detroit 24
Bedwell, Wm. L.....1249 Washington Blvd., Detroit 26
Beebe, Willard E.....20203 Ann Arbor Tr., Dearborn 6
Beekhuis, G. Jan.....1326 St. Antoine St., Detroit 7
Beeuwkes, L. E.....13014 MacKenzie Ave., Detroit 28
Behan, Robt. C.....1 Woodward Ave., Detroit
Beitman, Max R.....510 Kales Bldg., Detroit 26
Belanger, W. Geo.....1041 Harvard, Detroit 30
Belden, Darwin F.....2424 Puritan, Detroit 38
Bell, J. Kenner.....660 Woodward Ave., Detroit 26
Bende, Sandor F.....15863 Garfield, Allen Park
Beninson, Joseph.....Henry Ford Hospital, Detroit 2
Bennett, Germany E.....1446 E. Forest, Detroit
Bennett, Harry B.....17320 Livernois, Detroit
Bennett, H. Stanley.....15101 Southfield, Allen Park
Bennett, Sanford A.....15301 W. Nine Mile Rd., Oak Park 37
Bennett, Zina B. (L).....10319 Lanark, Detroit 24
Bennish, E. Leo.....14438 W. Six Mile Rd., Detroit
Benson, Clifford D.....1553 Woodward Ave., Detroit 26
Benson, Davis A.....17563 Greenfield, Detroit 35
Benson, Paul J.....2355 Fort St., Lincoln Park
Benson, Virginia M.....16238 Snowden Ave., Detroit 35
Bentley, Wm. G.....50 Westminster, Detroit 2
Berdayes, Pedro P.....13316 Pembroke, Detroit 35
Berger, Edwin L.....7301 Schaefer Rd., Dearborn
Bergman, Murray S.....4400 Livernois Ave., Detroit 10
Berke, Sydney S.....3333 E. Jefferson, Detroit 7
Berlin, Allen B.....17000 W. 8 Mile Rd., Southfield
Berman, Charles.....Highland Park Gen. Hosp., Highland Park 3
Berman, Lawrence.....1401 Rivard St., Detroit 7
Berman, Robt. H.....2111 Woodward, Detroit 1
Berman, Sidney L.....60 W. Hancock, Detroit 1
Bernard, Walter G.....910 Chalmer, Detroit 15
Bernbaum, Bernard.....17320 Livernois, Detroit 21
Bernstein, Saml. S.....18200 Wyoming, Detroit 21
Berridge, William L.....Chevrolet Motor Co., Livonia
Berry, Jos. E.....19242 W. 7 Mile Rd., Detroit 19
Besancon, John H.....1510 Broderick Tower, Detroit 26
Best, Thos. H. E. (L).....9221 E. Jefferson Ave., Detroit 14
Betanzos, G.....8425 12 Mile Rd., Warren
Bialik, Michael H.....14853 Michigan Ave., Dearborn
Bicknell, Frank B.....938 David Whitney Bldg., Detroit 26
Bielawski, John G.....825 David Whitney Bldg., Detroit 26
Bigman, Oscar.....18400 Schaefer Rd., Detroit 35
Bihl, John H.....15800 W. McNichols Rd., Detroit 35
Billingslea, Thos. H.....2175 Willis Ave. E., Detroit 7
Birch, John R.....925 David Whitney Bldg., Detroit 26
Birk, Robert E.....Henry Ford Hospital, Detroit 2
Birkam, Fred F.....7301 Schaefer Rd., Dearborn
Birkelo, Carl C. (R).....1630 Chestnut, Winter Park, Fla.
Birkhill, F. Ross.....31 Shady Hollow Dr., Dearborn
Birndorf, Leonard.....18317 John R St., Detroit 3
Bishai, Yousef B.....12645 Gratiot, Detroit 5
Bittker, Isadore I. (L).....3321 Rochester Rd., Royal Oak

Bittrich, Norbert M.....2500 W. Grand Blvd., Detroit 8
Black, Robert W.....641 David Whitney Bldg, Detroit 26
Blain, Alexander, III .....2201 E. Jefferson, Detroit 7
Blain, James H., Jr.....119 Kercheval Rd., Detroit 36
Blaine, Max.....13700 Woodward, Detroit 3
Blair, Wm. F.....81 E. Kirby St., Detroit 2
Blanchard, Russell S.....12858 Woodward Ave., Detroit
Blanks, Douglas H.....3955 Fort St., Lincoln Park
Blass, Norman H.....1800 Tuxedo, Detroit 6
Blatt, Ronald W.....300 Cadillac Sq. Bldg., Detroit 26
Bleier, Alfred.....13015 E. Warren Ave., Detroit 15
Bleier, Jos. (L).....7504 Dexter Blvd., Detroit 6
Blinkhorn, David H.....701 Doctors Bldg., Detroit 1
Bloch, Abraham (L)....2935 E. Milwaukee Ave., Detroit 11
Block, Duane L.....3001 Miller Rd., Dearborn
Block, Melvin A.....2799 W. Grand Blvd., Detroit 2
Blodgett, James B.....76 W. Adams St., Detroit 26
Blodgett, Wm. E. (L).....76 W. Adams St., Detroit 26
Blodgett, Wm. H.....74 W. Adams Ave., Detroit 26
Blondy, Marshall J.....19009 W. 7 Mile Rd., Detroit 19
Bloom, Albert.....6484 Chene St., Detroit 11
Bloom, Arthur R.....19140 Gloucester, Detroit 3
Bloom, Victor.....951 E. Lafayette, Detroit 7
Bloomberg, Sanford.....18916 Woodward Ave., Detroit 3
Bluhm, Gilbert B.....Henry Ford Hospital, Detroit 2
Blum, George L.....18200 Wyoming, Detroit 21
Blumenthal, Frank S.....261 Brady, Detroit 1
Blumenthal, Franz L. (L)....3011 W. Grand Blvd., Detroit 2
Blumer, Abraham.....21415 W. Eight Mile Rd., Detroit 19
Boccaccio, John L.....11532 Morang, Detroit 24
Boccia, James J.....15761 E. Warren, Detroit 24
Boddie, Arthur W.....2737 Chene St., Detroit 7
Bogucki, Chester J.....8110 Bliss, Detroit 34
Bogue, Robt. E.....15800 W. McNichols Rd., Detroit 35
Bogusz, Ladislaus (R).....29215 Maranya Rd., Homestead, Fla.
Bohn, Z. Stephen.....327 Professional Bldg., Detroit 1
Bohne, A. Waite.....Henry Ford Hosp., Detroit 2
Boland, John R. (R).....Box 50, Grand Marais
Boles, Murray.....26381 Dundalk Lane, Farmington
Bolstad, Donald S.....Henry Ford Hosp., Detroit 2
Bolter, Sidney.....18946 W. McNichols, Detroit 19
Bolton, Russell P., Jr.....19566 Grand River Ave., Detroit 23
Boman, Robert H.....12650 E. Outer Dr., Detroit 24
Bookstein, Abraham M.....1725 Pinecrest Dr., Ferndale
Boone, Geo. F.....1328 Joliet, Detroit
Booth, Earnest.....Woman's Hospital, Detroit 1
Borchak, Robert G.....12408 Van Dyke, Detroit 34
Borden, Igor I.....15361 Plymouth Rd., Detroit 27
Borin, Maurice C.....18115 Fairfield St., Detroit 21
Bornstein, M.....17600 Northland Pk. Ct., Southfield
Bornstein, Sidney.....2033 Puritan, Detroit 3
Borrego, Jose M.....1342 Whittier, Grosse Pointe
Bott, Edmund T.....1629 Ford, Wyandotte
Botvinick, Isadore.....13701 W. 7 Mile Rd., Detroit 35
Boutrous, Thos. A.....15801 W. McNichols, Detroit 35
Bower, Donald W.....719 Liberty, Lincoln Park
Bowers, Leo J.....11200 E. McNichols Rd., Detroit 34
Bowlby, James R.....15420 Farmington Rd., Livonia
Bownes, Eugene A.....18520 Grand River, Detroit 23
Boyajian, Albert.....10963 Farmington, Livonia
Boyd, John H.....2615 W. Jefferson, Trenton
Boyle, Albert J.....Wayne St. University, Detroit 2
Boyle, Eugene H.....572 Thorn Tree Rd., Grosse Pointe Woods
Boyle, Robert E.....7350 Cooley Lake Rd., Union Lake
Bracken, Andrew H.....5460 Schaeffer, Dearborn
Braden, Robt. G. (A).....25060 E. River Place, Grosse Isle
Bradfield, Horace F.....3008 E. Grand Blvd., Detroit 2
Bradley, Geo. T.....1553 Woodward Ave., Detroit 26
Braley, Wm. N. (L).....12897 Woodward, Detroit 3
Bramigk, Fritz W. (L).....509-511 Professional Bldg., Detroit 1
Brand, Benj.....4500 Wabash Ave., Detroit 8
Brandl, Earl A.....2860 Clark, Detroit 32
Braun, Lionel.....15121 W. McNichols Rd., Detroit 35
Braun, Robert A.....18610 Hartwell Ave., Detroit 35
Braverman, Morris M...20905 Greenfield Rd., Southfield 35
Bredau, Frank N., Jr.....24781 Five Mile Rd., Detroit
Breiner, Sander J.....14300 W. McNichols Rd., Detroit 21
Brekke, Viola G.....369 Glendale St., Highland Park 3
Bremer, John P.....17818 E. Warren, Detroit 24
Bremer, Wm. M.....15641 E. Warren, Detroit 24
Breneman, Gerald M.....28300 Forest Brook Dr., Farmington
Brennan, Michael J.....1168 Three Mile Dr., Grosse Pointe
Brent, Morris S.....1330 Strathcona Dr., Detroit 3
Brey, Norman W.....1900 David Broderick Twr., Detroit 26
Briegel, Walter A. (R).....1186 Buckingham, Birmingham
Briggs, Wm. J.....1900 David Broderick Twr., Detroit 26
Bringard, Elmer L.....20905 Greenfield, Southfield
Brinkman, G. L.....Henry Ford Hospital, Detroit 26
Briski, Jacob E.....21231 Sunnydale, St. Clair Shores
Brisson, John E.....14801 Southfield, Allen Park
Brisson, Jos. C.....9191 Whittier St., Detroit 24
Bristol, Wm. R.....189 Claverly, Detroit 36
Broadman, Sylvan A.....25705 Middlebelt, Farmington
Brock, Donald R.....36475 Five Mile Rd., Livonia
Broderson, Harvey S. (R).....10720 W. Jefferson, River Rouge 18
Bromme, Wm.....10 Peterboro St., Detroit 1
Brooks, Chas. W., II.....2033 E. Davison St., Detroit 12
Brooks, Eugene M.....609 Northland Med. Bldg., Southfield
Brooks, Nathan.....7401 3rd St., Detroit 2
Brosius, Chas. O.....15800 Six Mile Rd., Detroit 35
Brosius, Wm. L. (L).....1823 Fair Oak Court, Rochester
Brown, Andrew G.....20905 Greenfield, Southfield
Brown, Audrey O. (L).....46 Oakdale, Pleasant Ridge
Brown, Carlton F.....16552 Westmoreland Rd., Detroit 19
Brown, Chas. H.....2387 Fort St., Wyandotte
Brown, Eli M.....13123 LaSalle, Huntington Woods
Brown, Frances.....1940 Lincolnshire, Detroit 3
Brown, Gordon T.....13000 Hayes Ave., Detroit 5
Brown, Henry S. (L).....100 Oakman Blvd., Detroit
Brown, H. Zane (A).....Receiving Hospital, Detroit
Brown, John R.....1145 David Whitney Bldg., Detroit 26
Brown, Kenneth A.....5050 Joy Rd., Detroit 4
Brown, Robt. A.....3529 W. Jefferson Ave., Ecorse
Brown, Saml. M.....21821 Harding, Oak Park
Brown, Saul.....6890 White Pine Dr., Birmingham
Brown, Stanley H. (L).....8544 W. McNichols Rd., Detroit 21
Brown, Thos. A.....5430 W. Warren Ave., Detroit 10
Brownell, H. H.....10435 Groh, Grosse Isle
Brownell, Paul G.....18916 Woodward Ave., Detroit 3
Bruce, Thomas A.....16540 Shrewsbury, Detroit 21
Bruder, Robt. C.....4520 Firestone Ave., Dearborn
Bruer, Edgar S.....12170 Fort St., Wyandotte
Bruer, Edwin L.....12170 Fort St., Wyandotte
Brundage, Robt. D.....1914 Edgewood, Dearborn
Brush, Brock E.....2799 W. Grand Blvd., Detroit 2
Bruton, Martin F.....341 Massachusetts, Detroit 31
Bryan, Donald I.....13700 Woodward Ave., Highland Park 3
Bryan, John B.....2799 W. Grand Blvd., Detroit 2
Bryce, John D.....Med. Dispensary, APO, Detroit 33
Buell, John H. (R).....188 Provencal Rd., Detroit 36
Buerki, Robin C.....Henry Ford Hosp., Detroit 2
Buettgen, Jan W.....2900 S. Fort St., Detroit 17
Buller, Harry L. (A).....4120 Fenkell Ave., Detroit 38
Burge, Robert H.....28343 Joy Rd., Dearborn
Burke, Joseph J.....3333 E. Jefferson, Detroit 7
Burke, Ralph M.....580 University Pl., Grosse Pointe 30
Burnham, David C.....13700 Woodward Ave., Highland Park
Burnham, Thomas K.....Henry Ford Hospital, Detroit 2
Burns, Robert E.....Henry Ford Hospital, Detroit 2
Burns, Robt. T.....11110 Morang Rd., Detroit 24
Burnside, Howard B.....33 Oakland Park, Pleasant Ridge
Burnstine, David.....771 Fisher Bldg., Detroit 2
Burnstine, Julius Y. (L).....45 Owen Ave., Detroit 2
Burnstine, Perry P.....2329 W. Grand Blvd., Detroit 8
Burr, Geo. C. (L).....2016 W. Boston Blvd., Detroit 6
Burroughs, Roswell G.....31624 Auburn Dr., Birmingham
Burrows, Howard A.....10423 W. Warren Ave., Dearborn
Burstein, Harry S.....2950 W. Grand Blvd., Detroit 2
Burstein, I. Marvin.....2950 W. Grand Blvd., Detroit 2
Burstein, Morris M.....2950 W. Grand Blvd., Detroit 2
Burton, DeWitt T. (L).....54 Arden Park, Detroit 2
Burton, Irving F.....26912 York Rd., Huntington Woods
Bush, Glendon J.....18901 W. McNichols, Detroit 19
Butler, Harry J. (L).....33 Waverly Ave., Highland Park

Butler, James E.....2177 W. Grand Blvd., Detroit 8
Butler, John D.....2173 W. Grand Blvd., Detroit 8
Butler, J. Payne.....3403 W. Warren St., Detroit 8
Butler, Lawrence H.....14521 East 7 Mile Rd., Detroit 5
Butler, Richard G.....2021 Monroe, Dearborn
Butler, Volney N.....28 W. Adams Ave., Detroit 26
Buttrum, Edward J.....14755 Fenkell St., Detroit 27
Byers, Dudley W. (A).....8934 Oakland, Detroit 11
Cabral, Hector H.....13015 W. Chicago, Detroit 28
Cahalan, Jos. L.....15830 Fort St., Southgate
Cain, Waldo L.....8401 Woodward Ave., Detroit 2
Caldwell, Geo. L. (L)....12017 Joseph Campau, Detroit 12
Caldwell, John R.....2799 W. Grand Blvd., Detroit 2
Cameron, Arthur H. (L).....2853 Biddle Ave., Wyandotte
Cameron, Duncan A.....2021 Monroe, Dearborn
Campbell, Duncan (L).....330 Bush St., Apt. 1, Howell
Campbell, Everett W.....7901 W. Jefferson, Detroit 17
Campbell, Fredk. W., Jr.....Henry Ford Hospital, Detroit 2
Campbell, Harvey E.....25525 Graceland, Dearborn Heights
Campbell, Malcolm D. (L).....14950 Forrer, Detroit 27
Campbell, Mary B. (L).....10454 Kingston, Huntington Woods
Campbell, Robt. E.....8445 E. Jefferson Ave., Detroit 14
Campbell, Ruth B.....1536 David Whitney, Detroit 26
Campbell, Thelma M.....2355 Monroe Blvd., Dearborn
Candler, Clarence L. (L).....20040 Mack Ave., Detroit 36
Canter, Gayle E.....26 Waverly, Detroit 3
Cantor, Herbert C.....26831 N. Woodward, Huntington Woods
Cantor, Meyer O.....7850 Charing Cross, Bloomfield Hills
Cantow, Lawrence A.....19291 Warrington Dr., Detroit 21
Capellari, Elmer E.....Box 3059, Detroit
Capili, Apolinario M.....32707 Bertram Dr., Garden City
Capobres, David B.....1800 Tuxedo, Detroit 6
Caputo, Jos. M.....21831 Willoway, Dearborn
Caputo, Nancy T.....17712 Mack Ave., Grosse Pointe 30
Capuzzi, Eugene T.....24644 Gleneyrie Dr., Southfield
Caraway, James E. (R).....Rt. 1, Box 503, Franklin, N. C.
Carbone, Louis.....14711 Gratiot Ave., Detroit 5
Carbonell, Tomas.....353 Devonshire, Dearborn
Carlisle, John C.....15101 Southfield, Allen Park
Carlson, Harold W.....18070 Wildemere Ave., Detroit 21
Carnes, Harry E.....Parke Davis Co., Detroit 32
Carp, Jos.....8717 Van Dyke, Detroit 13
Carpenter, C. J. (L).....P.O. Box 390, Wayne
Carpenter, Glenn B. (L).....2751 W. Seven Mile Rd., Detroit 21
Carpenter, Wm. S.....18255 W. McNichols Rd., Detroit 19
Carr, James G. (L).....14111 Korte, Detroit 15
Carrick, Lee.....18050 Mack Ave., Grosse Pointe
Carroll, Elmer H.....9920 Stoepel Ave., Detroit 4
Carroll, Jerome G.....29588 Five Mile Rd., Livonia
Carroll, Lona B. (L)..938 David Whitney Bldg., Detroit 26
Carson, Herman J.....7745 Puritan Ave., Detroit 38
Carstens, Henry R. (L).....6896 N. Clunbury Rd., Birmingham
Carter, James A. U.....16637 Wildemere, Detroit 21
Carter, John M. (L).....2860 N.E. 55th Court, Ft. Lauderdale, Fla.
Carter, Leland F.....750 Middlesex, Detroit 30
Cash, Ralph.....19316 James Couzens, Detroit 35
Cassel, Harry E.....6742 Park Ave., Allen Park
Castle, Maurice E.....18980 Wyoming, Detroit 21
Caughey, Andrew F., Jr.....20041 W. Eight Mile Rd., Detroit 19
Caughey, Edgar H.....11301 Whittier St., Detroit 24
Caumartin, Fred E.....17184 Wildemere, Detroit 21
Cellar, Frank A., Jr.....6789 Woodward Ave., Royal Oak
Ceravolo, Albert J.....468 Cadieux Rd., Detroit 30
Ceresko, Anthony R.....9187 Mason Place, Detroit 9
Cetnar, Eugene J.....4322 Bishop, Detroit 24
Chajes, Richard.....15684 Joy Rd., Detroit
Chalat, Ned I.....1553 Woodward Ave., Detroit 26
Chall, Henry G.....2941 W. McNichols Rd., Detroit 21
Chapin, Sidney E.....125 N. Military, Dearborn 7
Chapman, Aaron L. (L).....406 W. Frisco Rd., Pensacola, Fla.
Chapman, Paul T.....1151 Taylor Ave., Detroit 2
Chapman, Roland H.....7600 John R St., Detroit 2
Chapman, Thomas H.....18901 Grand River Ave., Detroit 23
Chapnick, Henry A.....19322 Wyoming, Detroit 21
Chapper, Barbara M.....861 Monroe, Dearborn
Charnas, Sidney.....1129 David Whitney Bldg., Detroit 26
Chase, Clyde H. (R).....2922 Dawes St. S.E., Grand Rapids 8
Chason, Jacob L.....1401 Rivard St., Detroit 7
Chavis, William M.....15866 12th St., Detroit 21
Check, Frank E.....76 W. Adams Ave., Detroit 26
Chen, Allen S. Y.....Wayne Co. Gen. Hosp., Eloise
Chen, Calvin H.....State Hosp., Northville
Chen, Shek C.....1326 St. Antoine, Detroit 26
Chen, Vincent V.....987 E. Jefferson, Detroit 7
Chesluk, Herman M.....17191 J. Couzens Hwy., Detroit 35
Chester, Alice.....25085 Coolidge Hwy., Oak Park
Chester, Wm. P.....28 W. Adams Ave., Detroit 26
Childs, Geo. M.....2970 W. Grand Blvd., Detroit 2
Chipman, Willard A...14300 W. McNichols Rd., Detroit 35
Chipoco, Adolfo M.....25210 Grand River, Detroit 40
Chostner, Grover C. (R).....841 Eden Isle Blvd., St. Petersburg, Fla.
Chown, Marion C.....2025 Ford, Wyandotte
Christensen, R. C.....19635 Mack, Grosse Pointe Woods
Christopher, James G.....4777 E. Outer Dr., Detroit 34
Chrouch, Laurence A. (L).....Pleasant Hill, Tenn.
Church, Aloysius S.....19570 Bretton Dr., Detroit 23
Churchill, John A.....Lafayette Clinic, Detroit 7
Cioffari, Mario S.....15924 W. Seven Mile Rd., Detroit 35
Ciprian, Jos. E. (L).....1775 E. Grand Blvd., Detroit 11
Clapper, Muir.....1401 Rivard St., Detroit 7
Clark, Arthur M.....401 River Lane, Dearborn
Clark, Chas. J.....510 Hughes Rd., Howell
Clark, Clarence M. (L).....2605 Holbrook Ave., Detroit 12
Clark, Harold E. (L).....30761 Greenfield Rd., Southfield
Clark, Max D.....Henry Ford Hospital, Detroit 2
Clark, Wm. P.....1808 Baldwin, Ann Arbor
Clarke, Chas. N.....2501 W. Grand Blvd., Detroit 8
Clarke, Norman E. (L)....2501 W. Grand Blvd., Detroit 8
Clarke, Norman E., Jr.....2501 W. Grand Blvd., Detroit 8
Clarke, Robt. B.....76 W. Adams Ave., Detroit 26
Clemens, Raymond R.....23843 Joy, Dearborn
Clermont, Volna.....5050 Joy Road, Detroit 4
Clifford, John E.....8425 Twelve Mile Rd., Warren
Clifford, Thos. P. (L).....1750 David Whitney Bldg., Detroit 26
Climie, Andrew R. W.....Harper Hospital, Detroit 1
Cline, Richard S.....15101 Plymouth Rd., Detroit 27
Clune, John P.....226 Professional Bldg., Detroit 36
Coates, E. Osborne, Jr.....Henry Ford Hospital, Detroit 2
Cobane, John H.....10 Peterboro Ave., Detroit 1
Cochrane, Edgar G.....503 Med. Arts Bldg., Detroit 3
Cocorelis, S. G. (A).....104 W. Huron, Ann Arbor
Cohen, Herbert H.....12700 W. 7 Mile Rd., Detroit 35
Cohen, Melvin F.....20905 Greenfield, Southfield
Cohn, Danl. E.....409 Fox Bldg., Detroit 1
Cohn, Leonard S.....19105 W. Seven Mile Rd., Detroit 19
Cohoe, Don A. (L).....18916 Woodward Ave., Detroit 3
Cole, James E.....344 Glendale Ave., Detroit 3
Cole, Wyman C. C. (L).....1063 Fisher Bldg., Detroit 2
Cole, Wyman C. C., Jr.....3011 W. Grand Blvd., Detroit 2
Coleman, Margarete W. (L).....1209 S. Woodward, Royal Oak
Coleman, Peter F.....31410 Joy Rd., Livonia
Coleman, Wm. G.....20526 Grand River Ave., Detroit 19
Coles, Thomas B., Jr.....Grace Hospital, Detroit 1
Collier, Beverly A.....Henry Ford Hosp., Detroit 2
Collings, M. Raymond (A).....9201 W. Outer Dr., Detroit 19
Collins, James E.....13103 W. Chicago Blvd., Detroit 28
Colvin, Leslie T.....3011 W. Grand Blvd., Detroit 2
Colyer, Raymond G. (R).....284 Pilgrim, Birmingham
Combs, Julius V. (A).....Det. Receiving Hosp., Detroit 26
Comly, Hunter H.....5475 Woodward, Detroit 2
Compton, Wm. A., Jr.....36825 Bibbins, Romulus
Comstock, Lawrence A.....3700 West Rd., Trenton
Conklin, Emma J.....Wayne Co. Gen. Hosp., Eloise
Conley, Lowry C. M. (L).....99 Tuxedo Ave., Detroit 3
Connelly, Richard C.....1401 David Whitney Bldg., Detroit
Connolly, Paul J.....16778 Westmoreland Rd., Detroit 19
Connors, John J.....3546 Trumbull Ave., Detroit 8

Cook, James A.....2246 20th St., Wyandotte
Cook, James C.....3825 Brush St., Detroit 1
Cookinham, Frank.....999 S. Highland, Dearborn
Cooksey, Warren B.....801 Adams Rd., Birmingham
Cooper, James B.....18150 Mack Ave., Grosse Pointe 30
Cooper, Ralph R.....850 Lakeland, Grosse Pointe 30
Cooper, Richard F.....1245 David Whitney Bldg., Detroit 26
Corbeille, Catherine (L)....3011 W. Grand Blvd., Detroit 2
Corbett, David P.....Harper Hospital, Detroit 1
Cortez, Joseph A.....19350 W. McNichols, Detroit 15
Costa, Frank (A).....Crittenton Gen. Hosp., Detroit 6
Costello, Russell T.....3001 W. Grand Blvd., Detroit 2
Costello, Stephen D.....3418 Norwood, Trenton
Cotant, John F.....14341 W. McNichols, Detroit 35
Cotton, Schuyler O. (R).....7904 Vernor Hwy., Detroit 9
Coulter, Wm. J.....Drummond Island
Courville, Chas. J.....703 Northland Med. Bldg., Southfield
Cowan, Wilfrid (L).....14239 Chandler Pk. Dr., Detroit 13
Cowen, Leon B. (L).....1001 Kales Bldg., Detroit 26
Cowen, Robt. L. (L).....91 E. Kirby, Detroit 2
Coyle, James E.....573 Fisher Bldg., Detroit 2
Craig, Roy D.....829 Fisher Bldg., Detroit 2
Craig, Roy E.....74 Fontana Lane, Grosse Pointe Shores
Crawford, Robert I. (A).....Lyons
Crawley, Eugene H.....885 Bloomcrest, Birmingham
Crews, Thos. H. (L).....3011 W. Grand Blvd., Detroit 2
Crockett, E. E. J.....7341 W. Warren, Detroit 10
Croll, Leo J.....12703 W. 7 Mile Rd., Detroit 35
Croll, Maurice.....12703 W. Seven Mile Rd., Detroit 35
Cross, Harold E.....68 N. Deepland Rd., Grosse Pointe
Crossen, Robert J.....933 David Whitney Bldg., Detroit
Crossman, Lyman W.....Delray Hospital, Detroit 17
Croushore, James E.....3001 W. Grand Blvd., Detroit 2
Cubberly, Robt. B.....1800 Tuxedo St., Detroit 6
Cueto, Jose M.....4342 W. Vernor, Detroit 9
Cullis, Frank.....261 Brady, Detroit 1
Curhan, Jos. H.....18709 Meyers Road, Detroit 35
Curtis, Frank E. (L).....273 Kenwood Ct., Detroit 36
Curtiss, Wm. P.....22631 Mack Ave., St. Claire Shores
Cusick, Paul L.....1108 Stroh Bldg., Detroit 26
Czuj, John M.....17198 Oak Dr., Detroit 21

Daignault, F. M.....20905 Greenfield, Southfield
Daitch, Martin H.....13011 W. McNichols Rd., Detroit 35
Dale, Esther H.....1401 Rivard St., Detroit 7
Dale, Mark.....3702 E. 8 Mile Rd., Detroit 34
Dal Santo, G.....1401 Rivard St., Detroit 7
Daly, Eugene T.....24781 Fenkell, Detroit 29
Danforth, James C., Jr.....20175 Mack Ave., Detroit 36
Danforth, Robt. D.....20175 Mack Ave., Detroit 36
Danielski, John J.....563 Fisher Bldg., Detroit 2
Danz, George W.....1539 Ford, Wyandotte
Daoust, Patrick H.....15520 Garfield, Allen Park
Darling, Chas. E.....673 Fisher Bldg., Detroit 2
Darnley, James D.....24 Fairwood Blvd., Pleasant Ridge
Dashiell, Grayson F.....1800 Tuxedo, Detroit 6
Davidson, David M.....3011 W. Grand Blvd., Detroit 2
Davidson, Harold H.....19310 Wyoming, Detroit
Davidson, Harry O.....2799 W. Grand Blvd., Detroit 2
Davies, Thos. S. (L).....15115 E. Jefferson, Grosse Pointe 30
Davies, Windsor S.....28 W. Adams Ave., Detroit 26
Davis, Herbert A.....9901 Melbourne, Allen Park
Dawson, W. A. (R).....188 Lake Silver Dr. N.W., Winter Haven, Fla.
Day, A. Jackson.....245 Cloverly Rd., Detroit 36
Day, Francis T.....18540 Mack, Detroit 36
Day, Jay C.....1553 Woodward Ave., Detroit 26
Dean, Carleton R. (M).....Off. of Vocnl. Rehab., 42 Broadway, Room 1200, New York 4, N. Y.
Dean, George A.....19309 Greenfield, Detroit 35
De Busk, Roger W.....4160 John R St., Detroit 1
Deering, Robt. J.....1359 Champaign, Lincoln Park
Defever, Cyril R.....19787 Mack Ave., Detroit 36
De Giustino, Caesar.....1175 E. Grand Blvd., Detroit 11
De Groat, Albert F.....1151 Taylor Ave., Detroit 2
Delaini, Stella M.....3011 W. Grand Blvd., Detroit 2
De Lawrence, Betty J.....21576 Michigan Ave., Dearborn
De Lawrence, Thomas.....21576 Michigan Ave., Dearborn
Del Giorno, Thos. E.....St. John's Hospital, Detroit 36
Del Valle, Mario.....19936 Packard, Detroit 34
Dennis, Melvin S.....22146 Ford Rd., Dearborn
Denson, Andrew L. (A).....821 Medical Group, Ellsworth AFB, S. Dak.
Deponio, Sylvester A.....20215 Van Dyke Ave., Detroit 34
Deresz, Alphonse.....4204 E. Outer Dr., Detroit 34
Derleth, Paul E.....563 W. Oakridge Ave., Ferndale 20
Derr, John W.....1145 David Whitney Bldg., Detroit 26
Derrick, C. F.....3677 Fort St., Lincoln Park
De Smyter, Geo. C.....15527 E. Warren, Detroit 24
De Spelder, Ray E.....2970 W. Grand Blvd., Detroit 2
Deuby, Owen J.....15121 W. Seven Mile Rd., Detroit
Devine, Herbert W.....22101 Moross Rd., Detroit 36
Diakow, Lilian M.....1539 N. Line Rd., Wyandotte
Dibble, Harry F. (L).....1553 Woodward Ave., Detroit 26
Dickson, Basil R.....337 W. Grand Blvd., Detroit 16
Dickson, Elias L., Jr.....7716 Oakland Ave., Detroit 11
Dickson, Laurie C., Jr.....400 Lincoln Rd., Grosse Pointe 30
Dickson, Leon A.....5535 W. Chicago, Detroit 4
Dickson, Mary D.....18424 Mack Ave., Grosse Pointe 36
Diebel, Nelson W.....660 Cadieux Rd., Detroit 30
Diekman, Fred C.....15800 W. McNichols Rd., Detroit 35
Dietze, Margaret R.....861 Monroe, Dearborn
Dietzel, Hugo O. (R)....844 Hemlock Dr., San Carlos, Calif.
Di Lella, Leonard L.....Henry Ford Hospital, Detroit 2
Dill, Hugh L.....16114 E. Warren Ave., Detroit 24
Dill, J. Lewis.....18615 Birchcrest, Detroit 21
Di Loreto, Panfilo C.....285 Vincennes Pl., Detroit 36
Di Maso, Gennaro J.....21501 Kelly, East Detroit
Dimond, Geo. E.....18401 Bretton Dr., Detroit 23
Dionne, Paul E.....12500 E. 12 Mile Rd., Warren
Dittmer, Edwin F.....18342 Mack Ave., Detroit 36
Ditzler, John W.....581 Rivard Blvd., Detroit 30
Dixon, Fredk. W.....245 S. Martha, Dearborn
Dixon, Ray S. (L).....5001 Van Dyke, Detroit 13
Dodds, John C. (L).....30 Morand Rd., Detroit 36
Dodenhoff, Chas. F.....18031 Kelly Rd., Detroit 24
Dodrill, Forest D.....Woodberry Dr., Bloomfield Hills
Doering, Wendell R.....17555 James Couzens, Detroit 35
Doig, Victor F.....19676 Dale, Detroit 19
Dolan, Edward A.....22345 Cherry Hill, Dearborn
Dolega, Stanley F.....15640 E. Warren Ave., Detroit 24
Dolgoff, Sidney.....15600 Michigan Ave., Dearborn
Dolin, Simon.....2900 S. Fort St., Detroit 17
Domzalski, Casimir A.....5361 McDougall Ave., Detroit 11
Domzalski, Henry M.....15252 Gratiot Ave., Detroit 5
Donald, Douglas (L).....7815 E. Jefferson Ave., Detroit 14
Donath, Rolf W.....7430 Second, Detroit 2
Donovan, Eugene T.....13365 Michigan Ave., Dearborn
Donovan, Richard S.....17555 James Couzens, Detroit 35
Doran, John H.....15101 Plymouth Rd., Detroit 27
Dorman, Jack.....18245 Warrington Dr., Detroit 21
Dorsey, Edward C.....8344 E. Jefferson, Detroit 14
Dorsey, John M.....65 Moss Ave., Highland Park 3
Doty, Chester A. (L).....1553 Woodward Ave., Detroit 26
Doub, Howard P. (L).....2799 W. Grand Blvd., Detroit 2
Dougherty, Edw. A., Jr.....18241 W. McNichols Rd., Detroit 19
Douglas, Clair L. (L).....1553 Woodward Ave., Detroit 26
Douglass, Robt. C.....23023 Orchard Lake Rd., Farmington
Dovitz, Benj. W.....16820 Greenfield Ave., Detroit 35
Dowdle, Edward (L).....2258 W. Grand Blvd., Detroit 8
Downer, Ira G. (L).....8445 E. Jefferson Ave., Detroit 14
Downes, Geo. O.....15062 Houston, Detroit 5
Drake, Ellet H.....Henry Ford Hospital, Detroit 2
Drake, James J. (R).....8845 Marygrove Dr., Detroit 21
Drapiza, Ruth L.....22231 W. Outer Dr., Dearborn
Draves, Edward F.....19647 Joy Rd., Detroit 28
Drazek, Jos. A.....18980 Wyoming, Detroit 21
Drews, Robt. S.....12500 Broadstreet Blvd., Detroit 4
D'Sena Dorothy.....33000 Palmer Rd., Wayne
Dubin, Jos. J.....10401 W. Chicago Blvd., Detroit 4
Dubnove, Aaron (L).....2115 W. Grand Blvd., Detroit 8
Dubpernell, Martin S. (L).....4019 Gilbert St., Detroit 10
Dubpernell, Robt. O.....18595 Grand River, Detroit 23
Dudek, John J.....19244 Grand River, Detroit 23
Dumke, Paul R.....2799 W. Grand Blvd., Detroit 2
Duncan, James R.....8633 John R St., Detroit 2
Dundas, Edward M., Jr.....4520 Firestone, Dearborn
Dunlap, Henry A.....7815 Jefferson Ave. E., Detroit 14
Dunn, Cornelius E.....3496 Burns, Detroit 14

Dupler, Gerald E.....10 Peterboro, Detroit 1
Durham, Everett W.....23100 Cherry Hill Rd., Dearborn 7

Durham, Robt.....Henry Ford Hosp., Detroit 2
Dutcher, Dwight J.....711 S. Oxford, Detroit 36
Duwe, Frank A.....25321 Five Mile Rd., Detroit 39
Dwaihy, Paul J. (A).....14530 E. Warren, Detroit 15
Dwyer, Francis W.....14440 W. McNichols, Detroit 35
Dyer, H. Lorne.....44536 Chedworth, Northville
Dykema, Rosemary M.....18424 Mack Ave., Detroit 36
Dziuba, John F.....18901 W. Warren Ave., Detroit 28
Dzul, Paul.....14620 E. Seven Mile Rd., Detroit 5

Eades, Chas C.....19635 Mack Ave., Detroit 36
Eadie, Gordon A.....16083 Southampton St., Livonia
Eakins, F. J. (R).....Henderson County, Robards, Ky.
Easterly, Robt. L.....1404 Ford Ave., Wyandotte
Eaton, Crosby D.....3011 W. Grand Blvd., Detroit 2
Echt, Raymond J.....VA Hospital, Dearborn
Eckhous, Arthur W.....1015 Kales Bldg., Detroit 26
Economy, Donald E.....7854 Kentucky, Dearborn
Eder, Saml. J. (L).....19541 Cranbrook, Detroit
Edgar, Irving I.....1036 David Whitney Bldg., Detroit 26
Edmonds, Gerald W.....19795 St. Mary's Ave., Detroit 35
Edmonds, Wm. N. (L).....18525 Merriman Rd., Livonia
Edmondson, Robt. B.....18501 Mack Ave., Detroit 36
Edwards, James G.....17751 E. Warren Ave., Detroit 24
Egan, Charles F.....Wyandotte Gen. Hosp., Wyandotte
Eisenbrey, A. B.....Henry Ford Hosp., Detroit 2
Eisenstein, B.....210 Professional Bldg., Detroit 1
Eisman, Clarence H. (L).....1121 Whittier Rd., Grosse Pointe 30
Eldredge, Edward F.....18540 Mack Ave., Grosse Pointe 36
Elliott, Jos. P., Jr.....Henry Ford Hospital, Detroit 2
Elliott, Robt. N.....760 Fisher Bldg., Detroit 2
Ellis, Frank R.....880 S. Lafayette, Dearborn 7
Elman, Meyer J.....108 W. Hancock, Detroit
Elson, Abraham L.....Lafayette Clinic, Detroit 7
Elvidge, Robt. J.....2900 W. Grand Blvd., Detroit 2
Emmert, Herman C. (L).....4927 N. 34th, Arlington 7, Va.
Endler, Gerhard C.....1394 Roslyn Rd., Grosse Pointe Woods
Enfroy, Henri L.....19980 Shrewsburg, Detroit 21
Engel, Earl H.....2336 Van Alstyne Blvd., Wyandotte
Engstrom, Fredk. W.....2021 Monroe, Dearborn
Engstrom, Ruby M.....1777 Culver Ave., Dearborn
Eno, Laurel S.....212 Eastland Pr. Bldg., Detroit 36
Ensign, Dwight C.....Franklin
Erickson, Eldon W.....25750 W. Outer Dr., Lincoln Park
Erickson, Miles A.....1932 Ford Ave., Wyandotte
Erman, Jos. M.....19530 Stratford Rd., Detroit 21
Ernest, Reginald H.....5050 Joy Rd., Detroit 4
Eschbach, Jos W.....935 S. Military St., Dearborn
Eurs, Frank J.....1340 Maccabees Bldg., Detroit 2
Evans, Gomer P., Jr.....1553 Woodward Ave., Detroit 26
Evans, Jos. M.....16431 Harper, Detroit 24
Ewing Chas. H.....17120 E. Warren, Detroit 24
Eyler, Wm. R.....2799 W. Grand Blvd., Detroit 2
Eyres, Alfred E.....17800 E. 8 Mile, Detroit 36

Fachnie, Harold L.....19203 Grand River, Detroit 23
Faello, Sebastian J.....16840 E. Warren Ave., Detroit 24
Fagan, James P.....987 E. Jefferson, Detroit 7
Fagin, Irving D.....18254 Livernois Ave., Detroit 21
Fahim, Ramfis B.....226 Eastland Prof. Bldg., Detroit 36
Falick, Mordecai L.....3011 W. Grand Blvd., Detroit 2
Falk, Ira E.....17411 Cherrylawn, Detroit 21
Fallis, Lawrence S.....2799 W. Grand, Detroit 2
Fandrich, Theodore S. (R).....3515 Chuparosa Dr., Santa Barbara, Calif.
Farbman, Aaron A.....14515 Kercheval, Detroit 15
Farina, Angel M.....23550 Joy Rd., Detroit 39
Farmer, Wm. L., Jr.....3335 W. Davison, Detroit 38
Farnam, Larry M., Jr.....19787 Mack Ave., Detroit 36
Faunce, Sherman P.....1824 Seminole St., Detroit 14
Fea, John F.....Mt. Carmel Mercy Hosp., Detroit 35
Feigelson, Howard H.....Sinai Hospital, Detroit 35
Felcyn, W. Geo.....2091 W Grand Blvd., Detroit 8
Feld, David.....15101 W. McNichols Rd., Detroit 35
Feldkamp, Lee E.....360 N. Main, Plymouth
Feldman, Irwin.....987 E. Jefferson Ave., Detroit 7
Feldman, Nathanial L.....24370 Tamarack Circle, Southfield
Feldman, Paul H.....16800 Greenfield, Detroit 35
Feldstein, Martin Z.....13345 W. McNichols Rd., Detroit 35
Fellner, Wm. A.....3202 Gen. Motors Bldg., Detroit 2
Fellows, William R.....3815 Pelham, Dearborn
Fenech, Harold B.....324 Professional Bldg., Detroit 1
Fenner, Wm. G.....12454 E. Outer Dr., Detroit 24
Fennessey, John F.....512 Rivard, Grosse Pointe 30
Fenton, Edwin H.....15125 Grand River Ave., Detroit 27
Fenton, Meryl M.....8600 W. McNichols Rd., Detroit 21
Fenton, Russell F.....15125 Grand River Ave., Detroit 27
Fenton, Stanley C.....15618 E. Warren, Detroit 24
Fentress, Vance.....641 David Whitney Bldg., Detroit 26
Feringa, Philip J.....20901 Moross Rd., Detroit 36
Ferrara, Richard J.....20045 Mack Ave., Grosse Pointe Woods
Ferrara, Virginia M.....18422 Woodward, Detroit 3
Ferris, George N.....20001 Greenfield, Detroit 35
Ferszt, Marion S.....18019 Rutherford, Detroit 35
Figiel, Leo S.....1500 Balmoral, Grosse Pointe
Figiel, Steven J.....4160 John R St., Detroit 1
Filkin, Lawrence E.....621 Fairbrook, Northville
Fill, Leon.....987 E. Jefferson, Detroit 7
Finch, Alvis D.....18000 Jas. Couzens Hwy., Detroit 35
Finch, F. Sinclair.....894 N. Renaud, Detroit 36
Finck, Jerome H.....25841 Plymouth, Detroit 39
Fine, Edward.....1112 Kales Bldg., Detroit 26
Fine, Gerald.....Henry Ford Hosp., Detroit 2
Fink, Saml.....10161 Burton, Oak Park
Finkelstein, Lionel.....15800 W. McNichols Rd., Detroit 27
Finkelstein, M. B.....18254 Livernois, Detroit 21
Firestone, N. S.....10151 Michigan Ave., Dearborn
Firnschild, Paul G.....10538 Andrews, Allen Park
Fischer, Arthur J.....36016 Five Mile Rd., Livonia
Fischer, Fredk. J.....654 Fischer Bldg., Detroit
Fischhoff, Jos.....18674 Fairfield, Detroit 21
Fishbein, Herbert L.....987 E. Jefferson Ave., Detroit 7
Fisher, Geo. S.....1709 David Whitney Bldg., Detroit 26
Fisher, James M.....176 Merriweather, Grosse Pointe 36
Fisher, Ralph L.....8445 E. Jefferson Ave., Detroit 14
Fitzgerald, C. H.....Wayne Co. Gen. Hospital, Eloise
Fitzgerald, James M.....15801 W. McNichols, Detroit 35
Fitzpatrick, F. W.....17187 Schaefer, Detroit 35
Flaherty, Henry J.....19600 W. McNichols Rd., Detroit 19
Flaherty, Norman W.....24315 Fairmont Dr., Dearborn
Flake, Thomas M.....5050 Joy Rd., Detroit 4
Fleming, Jos. L.....4218 Wendell Rd., Orchard Lake
Flora, Wm. R.....8100 E. Jefferson Ave., Detroit 14
Flower, James A. (R).....14140 Puritan Ave., Detroit 27
Floyd, William S.....19105 W. Seven Mile Rd., Detroit 19
Fogt, Herbert E. (L).....11801 Morang Dr., Detroit 24
Fogt, Robt. G.....11801 Morang Dr., Detroit 24
Foley, Hugh S. (L).....23100 Cherryhill, Dearborn
Foote, John A.....1336 Southfield Road, Lincoln Park
Ford, Geo. A. (L).....28 W. Adams Ave., Detroit 26
Fordell, Frank S.....22159 W. Outer Dr., Dearborn
Forgrave, Edward G.....18520 Grand River, Detroit 23
Forrer, Gordon R.....20141 James Couzens, Detroit 35
Fosnaugh, Robert P.....23185 Timberline, Southfield
Foster, E. Bruce.....20905 Greenfield Rd., Southfield
Foster, Owen C. (L).....1553 Woodward Ave., Detroit 26
Foster, Wallace M.....13700 Woodward Ave., Highland Park 3
Fowler, Melvin E.....247 E. Warren St., Detroit 1
Fraiberg, Paul L.....13001 W. Chicago Blvd., Detroit 28
Frame, Boy.....18694 Warrington Dr., Detroit 21
France, Chas. J.....838 Berkshire Rd., Grosse Pointe 30
Franjac, Marion J.....25447 Plymouth Rd., Detroit 39
Franklin, John E.....4075 Ink Rd., Inkster
Franzen, Nils A.....19566 W. Grand River, Detroit 23
Frazer, Mary M. (L).....748 Seminole, Detroit 14
Frederickson, Geo. C.....7430 Second, Detroit 2
Free, Harry W.....14300 W. McNichols, Detroit 35
Freedman, Arthur M.....7701 Wyoming, Dearborn
Freedman, John (R).....4853 Second Blvd., Detroit 1
Freeman, Donald K.....881 Chalmers St., Detroit 15
Freeman, Mable.....1316 David Broderick Twr., Detroit 26
Freeman, Michael W.....1810 Wellesley Dr., Detroit 3
Freeman, Wilmer.....940 East 7 Mile Rd., Detroit 3
Freid, Samuel.....17537 Parkside, Detroit 21

Freier, Andrew A.....19321 Greenfield, Detroit 35
Freier, Morton L.....13051 Puritan Ave., Detroit 27
Freilich, Olga.....746 Collingwood, Detroit
Freitas, Eugene L.....St. John's Hospital, Detroit 36
Fremont, J. Courtney.....1202-4 David Whitney Bldg., Detroit 26
Frey, James L.....1553 Woodward Ave., Detroit 26

Friedlaender, Alex S.....10300 W. Seven Mile Rd., Detroit 21
Friedlaender, Sidney..10300 W. Seven Mile Rd., Detroit 21
Friedlander, Joseph (A).....3776 Leslie, Detroit 38
Friedman, David.....2429 E. Milwaukee Ave., Detroit 11
Friedman, Isidor H.....3773 2nd Ave., Detroit 1
Friedman, Seymour.....5132 Allen Rd., Allen Park
Frisch, Emanuel.....1800 Tuxedo, Detroit 6
Frost, Harold M.....Henry Ford Hosp., Detroit 2
Frost, Richard G.....1800 Tuxedo, Detroit 6
Fryfogle, James D.....Cd. 8, Med. Concourse, Northland Center, Southfield
Fulgenzi, William R.....1305 Kales Bldg., Detroit 26
Fuller, Hugh M.....1257 David Whitney Bldg., Detroit 26
Fulton, Wm. J. (R).....Wye Ferry, Queenstown, Md.

Gaffney, J. Mitchell.....13600 Ohio, Detroit 21
Gagliardi, Carl A.....3516 Fort St., Lincoln Park
Gahagan, Thomas.....Henry Ford Hospital, Detroit 2
Gajewski, John E.....Parke Davis and Co., Detroit 32
Galacz, Robert J.....1833 18th Street, Wyandotte
Galantowicz, H. C.....7433 Mich. Ave., Detroit 10
Galantowicz, Thos. H.....20217 Ann Arbor Trail, Dearborn
Galdonyi, Laslo (L).....2311 Dav. Broderick Twr., Detroit 26
Galdonyi, Nicholas (L).....8001 W. Jefferson Ave., Detroit 17
Galerneau, Darrel B. (L).....7394 Engleman, Centerline
Gall, Henry.....275 W. Grand Blvd., Detroit 16
Gallant, Vincent J.....53 Chicago Bldg., Detroit 2
Ganos, Thos.....6742 Park Ave., Allen Park
Gans, Robert I.....7310 W. Seven Mile Rd., Detroit 21
Ganschow, John H.....1840 Holbrook Ave., Detroit 12
Gardner, Lawrence W.....6071 W. Outer Dr., Detroit 35
Gardner, Max L.....19557 Mack Ave., Grosse Pointe
Gariepy, Louis B.....16401 Grand River St., Detroit 27
Gariepy, Louis J. (L).....16401 Grand River, Detroit 27
Gass, H. Harvey.....529 Fisher Bldg., Detroit 2
Gaston, Herbert B.....7501 W. Morrow Circle, Dearborn
Gates, Nathaniel (L).....516 Professional Bldg., Detroit 1
Gaynor, Alex.....1755 E. 7 Mile Rd., Detroit 3
Gehring, Harold W.....20211 Greenfield, Detroit 35
Geib, Ledru O. (L).....3528 Van Dyke Ave., Detroit 14
Geitz, Wm. A. (R).....Box 1133, Boca Raton, Fla.
Gelbach, Philip D.....2900 S. Fort St., Detroit 17
Gemeroy, Jos. C.....962 Fisher Bldg., Detroit 2
Gerisch, Robt. A.....1217 Dav. Whitney Bldg., Detroit 26
Gerondale, Elmond J. (L).....3001 W. Grand Blvd., Detroit 2
Gibson, Dunbar P.....Box 1256, Detroit 31
Gibson, Wm.....7440 Mack Ave., Detroit 14
Giese, Fred W.....18526 Schoolcraft, Detroit 23
Gigante, Nicola.....10 Peterboro, Detroit 1
Gigliotti, David.....2500 W. Grand Blvd., Detroit 8
Gilbert, Harold R.....13146 Phelps, Wyandotte
Giles, Conrad L.....407 Northland Med. Bldg., Southfield
Gillespie, Stephen M.....23100 Cherry Hill, Dearborn
Gilpin, Watson A.....1539 Lockridge, Bloomfield Hills
Gilreath, James L.....1800 Tuxedo, Detroit 6
Gilroy, John.....John Harper Hospital, Detroit
Gimbel, Nicholas S.....1800 Tuxedo, Detroit 6
Ginsberg, Harold I.....15344 McNichols Rd., Detroit 35
Gitlin, Chas.....2424 Oakman Blvd., Detroit 35
Gittins, Perry C.....20905 Greenfield Rd., Southfield
Givens, Donovan H.....3453 Charlevoix Ave., Detroit 7
Gizynski, Waldemar E.....15400 Edington Rd., Livonia
Glass, Wayne W.....Wayne County Gen. Hosp., Eloise
Glasgow, Gordon K.....1174 3 Mile Rd., Grosse Pointe 30
Glassman, Saml. (L).....9233 Emerson Srf. Sd., Miami Beach, Fla.
Glazer, Walter S.....1490 Charrington Rd., Birmingham
Glees, John L.....P.O. Box 1318, Detroit
Glemet, Raymond B. (L).....216 W. Grand Blvd., Detroit 16
Glikman, Victor.....20131 James Couzens, Detroit 35
Glowacki, Ben F.....8 Mile & Greenfield, Southfield
Glowacki, Edward T.....20162 Wedge Wood, Grosse Pte. Wds.
Glowacki, Raymond M.....961 Monroe, Dearborn
Godley, Alegro J.....8401 Woodward, Detroit
Goerke, Elmer A.....36663 Goddard Rd., Romulus
Goetz, Angus G.....1553 Woodward Ave., Detroit 26
Goins, Wm. F.....6675 Tireman, Detroit 4
Goldberg, Arthur.....340 E. Eight Mile Rd., Detroit 3
Goldberg, Harry H. (L).....2211 Woodward Ave., Detroit 1
Goldberg, Nathan H. (L).....2211 Woodward Ave., Detroit 1
Golden, Alfred.....26764 York Rd., Huntington Woods
Goldfaden, Alfred.....6658 W. Fort St., Detroit 9
Goldman, Aubrey.....17191 James Couzens, Detroit 35
Goldman, Perry.....16805 Princeton, Detroit 21
Goldman, Robert T.....Wayne County Hospital, Eloise
Goldrath, Milton H.....17000 W. 8 Mile Rd., Southfield
Goldstein, Abe S.....18450 North Lawn, Detroit 21
Goldstein, Sidney (A).....Northville State Hosp., Northville
Gollman, Maurice D.....17000 W. Eight Mile Rd., Southfield
Gomez, Manuel R.....Mayo Clinic, Rochester, Minnesota
Gomley, Romuald H.....7220 Gratiot Ave., Detroit 13
Goodman, Maxwell M.....22265 Garrison, Dearborn
Goodman, Virgil P.....762 Bedford Rd., Grosse Pte. Pk.
Goodwin, Warren W.....20131 James Couzens, Detroit 35
Goodwin, William P.....1616 Boston W., Detroit 6
Gordon, John W. (R).....15123 Artesian Ave., Detroit
Gordon, Wm. E.....18058 Greenfield, Detroit 35
Gorelick, Martin J.....23901 Michigan Ave., Dearborn
Gorning, Raymond P.....857 Marlborough Ave., Detroit 15
Gorvl, Stephen V.....21501 Kelly, East Detroit
Goslee, Leonard T.....4401 Conners, Detroit 15
Goss, Samuel B.....10 Peterboro, Detroit 1
Gotham, James E.....3825 Brush St., Detroit 1
Gottlieb, Jacques S.....951 E. Lafayette, Detroit 7
Gottschalk, Fred W. (L).....712 Kales Bldg., Detroit 26
Goux, Raymond S. (L).....545D Whitney Bldg., Detroit 26
Grabiel, Amado.....10151 Michigan, Dearborn
Grace, Jos. M.....27453 Rainbow Circle, Lathrup Village
Grady, Jos. A.....946 Three Mile Dr., Detroit 30
Graham, John G., Jr.....491 Lincoln Rd., Grosse Pointe 30
Graham, Theodore N.....2424 Puritan, Detroit 38
Granger, Francis L.....14160 Gratiot Ave., Detroit 5
Granger, George R.....705 David Whitney Bldg., Detroit 26
Grant, Abraham H.....18024 Sorrento, Detroit 35
Grant, Heman E. (L).....Lewiston
Gratton, Henri L. (L).....76 W. Adams Ave., Detroit 26
Graves, James H.....861 Fisher Bldg., Detroit 2
Gray, Howard O.....5050 Joy Rd., Detroit
Greek, Louis M.....12901 E. McNichols, Detroit 5
Green, Edward W.....2799 W. Grand Blvd., Detroit 2
Green, Ellis R. (L).....5172 Scotten Ave., Detroit 10
Green, Henry L.....24260 Dante, Oak Park
Green, Lewis.....13000 Grand River, Detroit 27
Green, Louis M.....14636 E. 7 Mile Rd., Detroit 5
Green, Milton M.....1180 Southfield Plaza, Southfield
Green, Nelson W.....15800 W. McNichols, Detroit 35
Greenberg, Jack R.....15743 W. 7 Mile Rd., Detroit 35
Greenberg, Julius J.....5328 W. Outer Dr., Detroit 35
Greenberg, Morris Z.....9105 Van Dyke, Detroit 13
Greenberg, Stanley.....20905 Greenfield, Southfield
Greene, John B.....2179 W. Grand Blvd., Detroit 8
Greenidge, Robt. I. (L).....4839 Beaubien, Detroit 1
Greenlee, Wm. T. (L).....15053 Maddelein, Detroit 5
Greenslit, Frank S.....U.S. Vets. Admin. Hosp., Dearborn
Gregory, Louis J.....47 Webber Place, Detroit 36
Greiner, Bert A.....14607 E. Seven Mile Rd., Detroit 5
Grekin, John N.....7421 W. Seven Mile Rd., Detroit 21
Grier, William H.....1575 E. Lafayette, Detroit 7
Griffin, Robert J.....17401 Mack Ave., Detroit 24
Griffiths, Sydney J.....15400 Plymouth Rd., Detroit 27
Grimaldi, Gregory J. (A).....2983 Seminole, Detroit 14
Grinstein, Alexander.....18466 Wildemere, Detroit 21
Grishkoff, M. A.....2201 E. Jefferson, Detroit 7
Griva-Lizlovs, S.....29901 Ford Rd., Garden City
Grob, Otto (A).....7385 Parkstone Lane, Birmingham
Gronemeyer, Wm. H.....1800 Tuxedo, Detroit 6
Gross, Louis.....18937 Van Dyke St., Detroit 34

Grossman, Solomon C.....26339 Woodward Ave., Huntington Woods
Guerrero, Jose.....13700 Woodward, Detroit 3
Guidot, Julian M.....13345 W. McNichols, Detroit 35
Guimaraes, Abilio S. (L).....7301 Schaffer Hwy., Dearborn
Guinan, Geo. E.....27614 Gainsborough, Inkster
Guindi, Sami F.....1080 Fisher Bldg., Detroit 2
Gulick, Arthur E.....4160 John R, Detroit 1
Gurdjian, Elisha S.....1553 Woodward Ave., Detroit 26
Gurri, Jose P.....3150 Carpenter, Detroit 12
Gurskis, Eugenia E.....504 Kales Bldg., Detroit 26
Gustafson, David C.....1 Lafayette Plaisance, Detroit 7
Gutow, Benjamin R.....20905 Greenfield, Southfield
Guyton, Jack S.....2799 W. Grand Blvd., Detroit 2
Hacker, Elaine M.....293 Merriweather Rd., Grosse Pointe Farms
Hackert, John L.....14551 Southfield Rd., Allen Park
Haddad, Benjamin F.....1010 Mich. Mutual Bldg., Detroit 26
Haddad, Elias D.....17830 E. Warren, Detroit
Hadesman, Donald.....985 E. Jefferson, Detroit 7
Haefele, Leslie P.....29108 Ford Rd., Garden City
Hagermoser, H. H. (A).....5991 Yorkshire, Detroit 24
Hagge, Donald R.....29594 W. Five Mile Rd., Livonia
Haidostian, B. H.....18456 Grand River, Detroit 23
Haitinger, K. S.....22175 Thorofare, Grosse Isle
Haking, Leonard.....14014 E. 7 Mile Rd., Detroit 5
Halekas, G. Peter.....21727 Mack Ave., St. Clair Shores
Hall, Arch H.....10 Peterboro, Detroit 1
Hall, E. Walter (L).....14189 Rosemont Rd., Detroit 23
Hall, Ralph E.....10 Peterboro St., Detroit 1
Hall Richard H.....474 Fisher Building, Detroit 2
Hall, Robt. J. (L).....6014 W. Fort St., Detroit 9
Hall, Winthrop D.....5237 Oakman Blvd., Dearborn
Hallen, Leonard J.....1335 Nicolet Pl., Detroit 7
Hamburg, Robt. H.....1515 Dav. Whitney Bldg., Detroit
Hamburger, Albert C.....13345 W. McNichols, Detroit
Hamburger, Stuart W.....18400 Schaefer Hwy., Detroit 35
Hamil, Brenton M.....Henry Ford Hosp., Detroit 2
Hamilton Norman C.....300 W. McNichols Rd., Detroit 3
Hammer, Edwin J.....16616 Mack Ave., Detroit 24
Hammer, Roy W.....11455 E. McNichols, Detroit 35
Hammond, Arthur E.....1553 Woodward Ave., Detroit 26
Hammond, James L. (L)....1006 Morse St., Oceanside, Cal.
Handel, Jack E.....1800 Tuxedo, Detroit 6
Hank, Emil J.....32316 Grand River, Farmington
Hansen, Fredk. E. (L).....18160 Birwood, W. Beverly Hills, Birmingham
Hansen, John W. (R).....8877 Perrin Dr., Livonia
Hanyi, Karl.....7645 Thornwood, Plymouth
Hardstaff, R. John (L).....648 Neff Rd., Grosse Pte. 30
Hardt, Barbara A. (A).....15867 Mansfield, Detroit 27
Hardy, Clarence M.....23019 Ecorse Rd., Taylor
Hardy, Geraldine M.....18145 Mack, Detroit 24
Hardy, Warren G.....801 Dav. Whitney Bldg., Detroit 26
Harelik, Ely W.....Detroit House of Correction, Plymouth
Harkaway, Roman W.....19125 Van Dyke, Detroit 34
Harley, Garth H.....451 Golfcrest Dr., Dearborn
Harley, Louis M.....4100 W. McNichols Rd., Detroit 21
Harm, Winfred B. (L).....16260 Cherrylawn Ave., Detroit 21
Harmon, Edwin L.....441 E. Jefferson, Detroit 26
Harmon, Walter, Jr.....2510 E. Davison, Detroit 12
Harper, Jesse T.....1252 Dav. Whitney Bldg., Detroit 26
Harrell, Voss (A).....1035 Oakwood Ave., Dearborn 7
Harrington, F. L.....14341 W. McNichols, Detroit 35
Harris, Harcourt G.....9141 Dexter Blvd., Detroit 6
Harris, Harold H.....8011 W. Vernor Highway, Detroit 9
Harris, Ivor D.....1245 David Whitney Bldg., Detroit 26
Hart, Charles E.....23845 Van Dyke, Centerline
Hart, John C.....9341 Moffat, Detroit 13
Hartkop, Henry H.....20055 Mack Ave., Detroit 36
Hartquist, Robt. J.....1495 Fort St., Wyandotte
Hartzell, John B.....7815 Jefferson Ave. E., Detroit 14
Hartzell, John M.....7815 E. Jefferson, Detroit 15
Hasley, Clyde K. (L).....2320 N. LaSalle Gardens, Detroit 6
Hasley, Danl. E. (R).....16512 Shaftsburg, Detroit 19
Hassett, Gerard R.....St. Marys Hospital, Livonia
Hassig, Walter W.....20914 Kelly, East Detroit
Hastings, Orville J.....15744 Harper Ave, Detroit 24
Haszczyc, Vladimir A.....3329 Yemana, Detroit 7
Hathaway, Hubert R. (A).....154 Englewood Rd., Springfield, Ohio
Haubrich, Wm. S.....Henry Ford Hosp., Detroit 2
Hause, Glen E.....18520 Grand River, Detroit 23
Hauser, I. Jerome.....7411 Third Ave., Detroit 2
Hauser, John E.....405 Northland Med. Bldg., Southfield
Hauser, Maurice J. (A).....7411 Third Ave., Detroit 2
Havers, Howard (L).....271 Kenwood Ct., Detroit 36
Hawkins, James W. (L).....3885 Prudence Drive, Sarasota, Fla.
Hayden, Royal C., Jr.....Henry Ford Hospital, Detroit 2
Hayes, Allen L.....17563 Greenfield, Detroit 35
Hazen, Roy S.....20526 Grand River Ave., Detroit 19
Heath, Leonard P.....1553 Woodward Ave., Detroit 26
Heavner, Lyle E.....119 Kercheval, Grosse Pointe 36
Hecht, Manes S.....25717 Coolidge, Oak Park 37
Heenan, Theophilus H.....1553 Woodward Ave., Detroit 26
Heideman, Louis E.....20211 Greenfield Rd., Detroit 35
Heil, Edward R.....19190 Greenfield, Detroit 35
Heins, Marilyn.....747 Lakeland, Grosse Pte. 30
Heldt, Richard F.....1951 Monroe Blvd., Dearborn
Heldt, Thos. J. (L).....2799 W. Grand Blvd., Detroit 2
Helman, Norman.....15001 W. Eight Mile Rd., Detroit 35
Hendelman, Manuel H.....17141 Hayes, Detroit 5
Henderson, Allison B.....9041 Dexter Blvd., Detroit 6
Henderson, Arthur B. (L).....10452 Mack Ave., Detroit 14
Henderson, Chas. W.....20905 Greenfield Rd., Southfield
Henderson, Frederic C.....18101 E. Warren, Detroit 24
Henderson, Harold (L).....20905 Greenfield Rd., Southfield
Henderson, Hugh W.....18101 E. Warren, Detroit 24
Henderson, Leslie T. (L).....14814 E. Warren, Detroit 15
Henderson, Wm. E. (L).....9341 Chalmers, Detroit 13
Henig, Fred N.....7605 W. Seven Mile Rd., Detroit 21
Henkin, Raymond.....17228 Shervilla, Southfield
Henkin, Wm. A.....18215 Greenfield, Detroit 35
Hennessey, Alan T.....Grace Hospital, Detroit 35
Henrich, Laurence E.....2501 W. Grand Blvd., Detroit 8
Henry, Robert C.....16127 Baylis, Detroit 21
Herbst, Harold B.....20482 Ardmore, Detroit 35
Hergt, Klaus.....30320 Pondsview Dr., Franklin
Herrold, Rose E.....1277 E. Grand Blvd., Detroit 11
Herschelmann, Roy F.....3343 Gratiot Ave., Detroit 7
Hertzler, Jack H.....3011 W. Grand Blvd., Detroit 2
Herwick, John T.....2799 W. Grand Blvd., Detroit 2
Hess, Joseph W.....Harper Hospital, Detroit 1
Hess, Murray W.....23860 Seneca, Oak Park 37
Heyman, Louis F.....19009 W. Seven Mile Rd., Detroit 19
Heyner, C. S.....28 W. Adams Avenue, Detroit 26
Heyner, Stanley A.....3424 Oakman Blvd., Detroit 4
Hickey, Jos.....23100 Cherry Hill, Dearborn
Hicks, Fredk. G.....1000 Westwood, Birmingham
Hildner, Frank J. (A).....16840 Monica, Detroit 21
Hill, Edward J., Jr.....208 David Whitney Bldg., Detroit 26
Hill, Raymond D.....14551 Southfield, Allen Park
Hill, Welford T.....6303 Mack Ave., Detroit
Hillenberg, Sidney J.....19350 W. 7 Mile Rd., Detroit 19
Hiller, Glenn I.....13700 Woodward Ave., Detroit 3
Hillyer, John W.....26151 Huron River Dr., Flat Rock
Hilton, Wm. E. (L).....5013 Harding, Detroit 13
Himmelhoch, A. J.....19220 Kingston Rd., Detroit
Hinchman, D. F.....27459 Five Mile Rd., Livonia
Hipps, Chauncey J.....2605 West Grand Blvd., Detroit 8
Hirsch, Leo J.....15800 W. McNichols, Detroit 35
Hirsch, Lore.....212 S. Melborn, Dearborn
Hirschfeld, A. H.....829 Fisher Bldg., Detroit 2
Hirschman, Louis J. (L).....2619 Munson Ave., Traverse City
Hoagland, F. L. (A).....716 E. Grand Blvd., Detroit 7
Hobbs, Donald V.....27305 Southfield Rd., Lathrup Village
Hochman, Morton M.....16633 Plymouth Rd., Detroit 27

Hodges, Jason.....26401 Harper, St. Clair Shores
Hodgkinson, Chas. P.....17546 Meadwood Ave., Lathrup Village
Hoffer, Thos.....5825 Allen Rd., Allen Park
Hoffman, Ben G.....19545 Shrewsbury, Detroit 21
Hoffman, Edward A.....7615 W. Vernor Hwy., Detroit 9
Hoffman, Edwin S. (R).....8106 E. Jefferson Ave., Detroit 14
Hoffman, Harry Y.....15085 E. Seven Mile Rd., Detroit 5
Hoffman, Henry A.....10015 E. Outer Dr., Detroit 24
Hoffman, Louis.....18203 Birchcrest Dr., Detroit 21
Hoffman, Milton C.....18555 E. Warren, Detroit 36
Hogikyan, Azat.....16901 W. McNichols Rd., Detroit 35
Holdredge, Jean M.....3011 W. Grand Blvd., Detroit 2
Hollander, Abraham J.....14327 Michigan Ave., Dearborn 2
Hollinger, F. Wayne.....8265 Gen. Mtrs. Bldg., Detroit 2
Hollis, Henry B.....6809 Sirena, Detroit 10
Holloway, Horace R.....12840 Linwood, Detroit 38
Holloway, Janet L.....7430 Second, Detroit 2
Holmes, Geo. F.....14729 Champaign, Allen Park
Holstein, Arthur P.....875 Balfour, Grosse Pte. 30
Holt, Chas. J., Jr.....1210 S. Oxford, Grosse Pte. 30
Holt, Henry T.....5050 Cass St., Detroit 2
Homeister, Eugene A.....12925 Pennsylvania Ave., Wyandotte
Honhart, Fred L. (L).....1405 Berkshire Road, Grosse Pointe 30
Hopkins, Andrew J.....10149 Michigan Ave., Dearborn
Hopkins, Scovell M.....910 Dav. Broderick Twr., Detroit
Horkins, Earl J.....10963 Farmington Rd., Livonia
Horn, Robt. C., Jr.....2799 W. Grand Blvd., Detroit 2
Hornbeck, Robert J.....31500 Schoolcraft Rd., Livonia
Horny, Hugo O.....619 Barrington Rd., Detroit 30
Horton, Reece H.....606 Northland Med. Ctr., Southfield
Horvath, James J.....1553 Woodward Ave., Detroit 26
Horvitz, Victor S.....18400 Schaefer Hwy., Detroit 35
Hoski, A. Joseph.....3919 John R., Detroit
Hotchkiss, Loris M.....33220 W. 7 Mile, Livonia
Howard, Philip J.....Henry Ford Hosp., Detroit 2
Howard, William K.....1800 Tuxedo, Detroit 6
Howell, Bert F.....10800 Whittier Rd., Detroit 24
Howell, James T.....2799 W. Grand Blvd., Detroit 2
Howes, Homer A.....1515 Dav. Whitney Bldg., Detroit 26
Howlett, Howard T.....868 Fisher Bldg., Detroit 2
Hoyos, Pedro G.....1401 Rivard St., Detroit 7
Hoyt, Charles N.....5475 Woodward Ave., Detroit 2
H'Romadko, Louis (L).....1075 Fisher Bldg., Detroit 2
Hubbard, John P., Jr.....14620 E. Seven Mile Rd., Detroit 5
Huber, Philip J.....1724 Bassett, Royal Oak
Hudson, J. Stewart (L).....17443 E. Jefferson Ave., Grosse Pointe 30
Hudson, Wm. A. (L).....502 S. Pine St., Harrison, Ark.
Hudspeth, E. Rae.....753 Fisher Bldg., Detroit 2
Huegli, Wilfred A.....16840 E. Warren Ave., Detroit 24
Huggins, H. Horne.....8355 Gratiot, Detroit 13
Hughes, Calvin H.....19959 Vernier, Harper Woods
Hughett, Arthur J.....19959 Vernier, Harper Woods
Hulick, Archie G.....4420 Springer, Royal Oak
Hull, Leroy W. (L).....6364 Cowell Rd., Brighton
Hullerman, Hugo V.....Childrens Hospital, Detroit 2
Hume, H. Ross, Jr.....1553 Woodward, Detroit 26
Huminski, Thaddeus S.....19244 Van Dyke Ave., Detroit 34
Hummel, Arthur R.....1020 3 Mile Dr., Grosse Pointe 30
Hunt, Theodore H.....19431 Van Dyke Ave., Detroit 34
Hunt, Verne G.....1553 Woodward Ave., Detroit 26
Hunter, Donald G.....3245 E. Jefferson, Detroit 17
Hunter, Robert B.....Henry Ford Hosp., Detroit 2
Husband, Chas. W. (L).....14500 W. McNichols, Detroit
Husband, Raymond C.....14500 W. McNichols, Detroit 35
Hutchins, M. Colton.....3011 W. Grand Blvd., Detroit 2
Hyatt, Jarvis M.....22340 Michigan Ave., Dearborn
Hyde, Fredk. W., Jr.....Grace Hospital, Detroit 1
Hyland, John R.....17200 Mack, Detroit 24
Hysni, Aliqemal.....8031 W. Vernor Hwy., Detroit 9

Iacobell, Peter H.....19300 Van Dyke, Detroit 34
Iacobellis, M.....22159 W. Outer Drive, Dearborn
Iglesias, Luis J.....20211 Greenfield, Detroit 35
Igna, Eli J.....2799 W. Grand Blvd., Detroit 2
Ignagni, Antonio.....275 W. Grand Blvd., Detroit 16
Indenbaum, Samuel.....18400 Schaefer Hwy., Detroit 35
Ine, Myung Yul.....1800 Tuxedo, Detroit 6
Ingberg, Harry O.....261 Brady, Detroit 1
Irvin, Earle A.....Ford Motor Co. American Rd., Dearborn
Irwin, Wm. A.....2500 W. Grand Blvd., Detroit 8
Isaacson, Arthur (L).....18989 San Juan, Detroit 21
Isaacson, Harold E.....15361 Plymouth Rd., Detroit
Isaacson, Jo D.....26008 Pembroke, Huntington Wds.
Israel, Barney B.....663 Fisher Bldg., Detroit 2
Israel, Kenneth.....10607 W. 7 Mile Rd., Detroit 21
Itkin, H. David.....(Address Unknown)
Iwata, Herbert T.....7611 Patton Ave., Detroit 28
Izner, Sanford M.....17500 Schaefer Hwy., Detroit 35

Jacknow, David.....60 W. Hancock, Detroit 1
Jackson, Lawrence E.....3710 Sturtevant, Detroit 6
Jacobs, Howard.....18241 Greenfield, Detroit 35
Jacobson, Lyle F.....5224 St. Antoine, Detroit 2
Jacobson, Saml. D.....Wayne Co. Genl. Hosp., Eloise
Jacobus, Wayne N.....20055 Mack Ave., Grosse Pte. 36
Jaeger, Grove A.....11711 Minden, Detroit 5
Jaekel, Clarence N.....1086 E. Grand Blvd., Detroit 7
Jaffar, Donald J.....671 Fisher Building, Detroit
Jaffe, Harold W.....1706 David Whitney Bldg., Detroit 26
Jaffe, Jacob.....2211 Woodward Ave., Detroit 1
Jaffe, Julius L.....7463 Harper Ave., Detroit 13
Jaffe, Louis.....18662 Muirland, Detroit 21
Jahsman, Wm. E. (R).....1410 Sunset Dr., Clearwater, Fla.
Jakacki, Richard Wm.....36157 Sherwood, Livonia
Jakobovits, Thomas.....15361 Plymouth, Detroit 27
James, Thomas N.....Henry Ford Hosp., Detroit 2
Jamieson, Thos. J.....1310 Warwick, Lincoln Park
Janicki, Natalia J.....Eloise Hosp., Eloise
Jarkowski, T. L.....Harper Hospital, Detroit 1
Jarre, Hans A. (L).....Grace Hospital, Detroit 1
Jarvis, Harold F.....360 Moross, Detroit 36
Jasion, Lawrence J. (A).....11945 Payton, Detroit 24
Jaslow, Robt. I.....Plymouth St. Trng. Sch., Northville
Jaynes, Richard V.....29901 Ford Rd., Garden City
Jeffries, Benj.....16321 Mack Ave., Detroit 24
Jend, Wm., Jr.....1365 Cass Ave., Detroit 26
Jend, Wm. J. (L).....12781 E. Outer Dr., Detroit 24
Jenkins, Elwood A.....1102 Dav. Whitney Bldg., Detroit 26
Jennings, Chas. G.....17700 Mack Ave., Detroit 24
Jensen, Viggo W.....532 Lincoln Rd., Detroit 30
Jeremias, Robt. C.....17563 Greenfield, Detroit 35
Jevons, William H.....8425 Twelve Mile Rd., Warren
Jewell, F. C.....159 Kercheval Ave., Detroit 36
Jewell, John S.....2021 Monroe, Suite 203, Dearborn
Jewell, Marvin R.....Childrens Hospital, Detroit 2
Jocz, Marion W.....945 Trombley Rd., Detroit 30
Jodar, Emery O.....15760 Mack Ave., Detroit 24
Jodar, Loyal W.....18412 Mack, Grosse Pointe 36
John, Hubert R. (L).....20905 Greenfield, Southfield
Johnson, Aran S.....1462 Hollywood, Grosse Pte. Wds. 30
Johnson, Arthur J.....Henry Ford Hospital, Detroit 2
Johnson, Gage (A).....3395 Scranton, Cleveland, Ohio
Johnson, Homer L.....2799 W. Grand Blvd., Detroit 2
Johnson, Ralph A.....7815 E. Jefferson Ave., Detroit 14
Johnson, Simon O.....Cadillac Sq. Bldg., Detroit 26
Johnson, Thos. D.....18530 Grand River, Detroit 23
Johnson, Verne E.....2051 Monroe Ave., Dearborn
Johnson, Vernon P.....21327 Harper Ave. St. Clair Shores
Johnson, Wilbur E.....14654 Gratiot, Detroit 5
Johnson, Wm. H. M. (L).....7157-63 Michigan, Detroit 10
Johnston, Everett V.....30130 Bristol Lane, Birmingham
Johnston, Herbert C.....3001 Miller Rd., Dearborn
Johnston, John L. (A).....1950 W. McNichols Rd., Detroit 3
Johnston, Jos. A.....Henry Ford Hosp., Detroit 2
Johnston, Wm. E.....3011 W. Grand Blvd., Detroit 2
Johnstone, Benj. I.....555 Fisher Bldg., Detroit 2
Joinville, Euclide V. (L).....1202 Stroh Bldg., Detroit 26
Jones, Adrian R.....15309 Mack Ave., Detroit 24

Jones, Arnold M.....3706 Sturtevant, Detroit 6
Jones, G. Richard.....18412 Mack Ave., Detroit 36
Jones, Roy D.....10234 Puritan Ave., Detroit 38
Jones, Wm. J.....8209 Allen Rd., Allen Park
Joos, Thad H.....20867 Mack, Grosse Pte. Woods
Jordan, Prescott, Jr.....5224 St. Antoine, Detroit 2
Jordan, R. Gerald.....12410 Van Dyke, Detroit 34
Joseph, Ramon R.....Wayne Co. Gen. Hospital, Eloise
Joyce, Stanley J.....1078 Fisher Bldg., Detroit 2
Joyrich, Myron H.....Sinai Hospital, Detroit 35
Juliar, Benj.....17305 Muirland Ave., Detroit 21
Jungwirth, R. V.....19350 W. McNichols Rd., Detroit 19

Kackley, James E.....18495 Mack, Detroit 36
Kain, Thomas R.....1400 Chrysler Exp. Way, Detroit 7
Kaine, Henry D.....3011 W. Grand Blvd., Detroit 2
Kalayjian, Bernard S.....30676 Harlincin Ct., Franklin
Kalichman, Nathan.....18440 Livernois, Detroit 21
Kallenbach, Rudolf W.....388 Inkster Rd., Inkster
Kallet, Herbert I.....651 Fisher Bldg., Detroit 2
Kallet, Maerit B.....1800 Tuxedo, Detroit 6
Kallman, David (L).....2351 W. Grand Blvd., Detroit 8
Kallman, Leo.....2351 W. Grand Blvd., Detroit 8
Kallman, Reuben R.....2631 Woodward Ave., Detroit 1
Kamil, Richard S.....14438 McNichols, Detroit 35
Kaminski, Zeno L. (L).....3510 24th St., Detroit 8
Kandel, Robert F.....Henry Ford Hospital, Detroit 2
Kane, Archibald V.....2500 W. Grand Blvd., Detroit 8
Kansa, Selma.....19431 Van Dyke, Detroit 34
Kapetansky, A. J.....1728 Clairmount, Detroit 6
Kapetansky, Don I.....18400 Schaefer, Detroit 35
Kapetansky, Nathan J.....1728 Clairmount, Detroit 6
Kaplita, Walter A.....60 Fontana Lane, Grosse Pte. Shores
Karamatas, Philip C.....13244 W. Warren, Dearborn
Karch, Saul.....18080 Muirland, Detroit 21
Kasabach, Harry Y.....1553 Woodward Ave., Detroit 26
Kasabach, Vahram Y.....1814 Book Tower, Detroit 26
Kashtan, Harry A.....17300 Schaefer, Detroit 35
Kasper, Jos. A.....19953 Clairview Ct., Detroit 36
Kaspor, Albert J.....20901 Moross Rd., Detroit 36
Kass, Arnold.....1316 David Stott Bldg., Detroit 26
Katz, Lawrence.....987 E. Jefferson, Detroit 7
Katz, Martin.....7300 Harding, Taylor
Katzman, Harold L.....412 Fox Bldg., Detroit 1
Katzman, Irving S.....412 Fox Bldg., Detroit 1
Kaufman, Jack H.....10234 W. 7 Mile Rd., Detroit
Kaufman, Louis W.....10326 W. Seven Mile, Detroit 21
Kaufman, William H.....10149 Michigan Ave., Dearborn
Kawchak, James.....Ford Motor Co., Dearborn
Kawecki, Lucian.....10734 Hart Ave., Huntington Woods
Kawel, Conrad A., Jr.....10955 Farmington Rd., Livonia
Kazdan, Morris.....4619 Allen Rd., Allen Park
Keating, Thos. F. (L).....18675 Gainsborough, Detroit 23
Kehoe, Henry J.....15252 Gratiot Ave., Detroit 5
Keith, Kelly.....106 W. Davison Ave., Highland Park 3
Keith, Rachel H. C. B.....5353 Joy Rd., Detroit 4
Kelley, Frank J.....3919 John R. St., Detroit
Kelly, A. P., Jr.....Henry Ford Hosp., Detroit 2
Kelly, John J.....14729 Champaign, Allen Park
Kelly, L. J.....14015 Gratiot, Detroit 5
Kelmenson, Victor A.....7356 12th St., Detroit 6
Kelson, Malcolm J.....1045 Harvard, Detroit 30
Kennary, James M.....4900 Cadieux Rd., Detroit 24
Kennary, James M., Jr.....4900 Cadieux Rd., Detroit 24
Kennedy, Chas. S. (L).....10 Peterboro St., Detroit 1
Kennedy, Donald J.....27030 Kingswood Dr., Dearborn
Kenning, John C. (A)..5703 LaJolla Hermosa, LaJolla, Cal.
Kermath, James E.....15101 Southfield, Allen Park
Kernick, Melvin O.....13700 Woodward Ave., Highland Park 3
Kernkamp, Ralph F. (L).....10 Witherell, Detroit 26
Kerwin, George R.....15324 James, Oak Park
Kessel, Karl J.....18031 Kelly Rd., Detroit 24
Kessler, Chas.....18241 Greenfield, Detroit 35
Keyes, John W.....Henry Ford Hosp., Detroit 2
Killins, Chas. G.....8100 E. Jefferson, Detroit 14
Kimberlin, K. K., Jr.....11110 Morang Dr., Detroit 24
King, Edward D. (L).....270 Rivard Blvd., Grosse Pte. 30
King, Melbourne J.....5435 W. Vernor Hwy., Detroit 9
King, Robert R.....261 Brady St., Detroit 1
Kingswood, Roy C.....1078 Fisher Bldg., Detroit 2
Kinsley, George.....15105 W. Seven Mile Rd., Detroit 35
Kitzmiller, John L.....15800 W. McNichols Ave., Detroit 35
Klaiber, Roger G.....1541 Edsel Dr., Trenton
Klein, Herman.....24030 Marlow St., Oak Park
Klein, Howard A.....1846 Dav. Whitney Bldg., Detroit 26
Klein, Sander P.....14825 W. McNichols Rd., Detroit 35
Klein, Wm.....13965 Linwood, Detroit 38
Kleinman, Shmarya (L).....1800 Tuxedo, Detroit 6
Kliger, David.....7756 Southfield, Detroit 28
Klimchuk, M. M.....22770 Kelly Rd., East Detroit
Kling, George A.....Harper Hospital, Detroit 1
Kling, Murray G.....18400 Schaefer Hwy., Detroit 35
Klosowski, Jos.....8222 E. Outer Dr., Detroit 13
Kluck, Clarence J.....25210 Grand River, Detroit 40
Klutke, Geo. H. E.....2841 Monroe, Dearborn
Knaggs, Earl J.....2387 Fort St., Wyandotte
Knapp, Floyd B. (R).....16565 Birwood, Detroit 27
Knapp, Gary H.....23611 Goddard, Taylor
Knapp, Gordon R. (R).....422 W. Goldengate, Detroit 3
Knapp, Wm. L.....20100 W. McNichols Rd., Detroit 19
Knighton, Robt. S.....2799 W. Grand Blvd., Detroit 2
Knights, Edwin M., Jr.....2500 W. Grand Blvd., Detroit 8
Knobloch, Edmund J.....5933 Chene St., Detroit 11
Knox, Ross M.....3180 Fort St., Lincoln Park
Kobernick, Sidney D.....6767 W. Outer Dr., Detroit 35
Kobiljak, Stefan H.....3516 Fort St., Lincoln Park
Koebel, Raymond H.....640 Bedford Lane, Grosse Pointe 30
Koek, Hendrik J.....23100 Cherry Hill, Dearborn
Koerber, Edward J.....4876 Lakeview Ave., Detroit 15
Kogut, Constantine S.....10627 Puritan, Detroit 38
Kokowicz, Raymond J.....19440 Van Dyke, Detroit 34
Kolman, Isadore I.....1800 Tuxedo, Detroit 6
Komisaruk, Richard.....1025 E. Forest, Detroit 7
Kopmeyer, Joe M., Jr.....17632 Grandville, Detroit 19
Koran, Valentine L.....1306 Kales Bldg., Detroit 26
Koren, Louis.....1300 Cadillac Sq. Bldg., Detroit 26
Korum, Lyle W.....18585 E. Warren St., Detroit 36
Koschnitzke, H. K.....15101 Southfield, Allen Park
Kossayda, Adam W.....15324 Michigan Ave., Dearborn
Kovach, Emery P.....9750 Chalmers, Detroit 13
Kovan, Dennis D.....16965 Hamilton Ave., Highland Park 3
Kowaleski, John J.....12789 Veronica, Southgate
Kozlinski, Anthony E.....2195 E. Grand Blvd., Detroit 11
Krabbenhoft, K. L.....3825 Brush St., Detroit 1
Kraft, Ruth M.....19164 Devonshire Rd., Birmingham
Krakauer, Bernard.....18424 W. McNichols Rd., Detroit 19
Krass, Edward W.....11088 Gratiot Ave., Detroit 13
Kraus, John J.....16840 E. Warren Ave., Detroit 24
Krawec, Charles J.....Mt. Carmel Mercy Hosp., Detroit 35
Krebs, Wm. T.....16419 E. Warren Ave., Detroit 24
Kreinbring, Geo. E.....14295 E. 7 Mile Rd., Detroit 5
Kretzschmar, John C.....660 E. Grand Blvd., Detroit 7
Krevsky, David A.....8461 Park Ave., Allen Park
Krevsky, Harold.....8461 Park Ave., Allen Park
Krieg, Earl G.....85 Kercheval Ave., Grosse Pte. Farms
Krieger, Harley L. (R).....11390 Strathmoor, Detroit 27
Krieger, Harvey.....954 Fisher Bldg., Detroit 2
Krieger, Ingeborg (A).....13112 Ladlow, Huntington Wds.
Kritchman, Maurice J.....10 Witherell St., Detroit 26
Kroha, Lawrence A.....15124 Kercheval Ave., Detroit 30
Krohn, Lawrence H.....24340 W. McNichols Rd., Detroit 19
Kroll, Harvey V.....7815 E. Jefferson, Detroit 14
Krynicki, Francis X.....15101 W. 7 Mile, Detroit 35
Krystal, Henry.....19210 Coyle, Detroit 35
Kubanek, Jos. L.....23134 Myrtle, Dearborn
Kucmierz, Francis S.....18934 Van Dyke Ave., Detroit 34
Kuehn, Ned N.....20203 Wellesley Blvd., Birmingham
Kuhn, Albert A.....635 W. Seven Mile Rd., Detroit 3
Kuhn, Henry H.....635 W. Seven Mile Rd., Detroit 3
Kuhn, Richard F.....1700 Junction Ave., Detroit 9
Kujawski, Walter F.....16840 E. Warren, Detroit 24
Kulaski, Chester H.....9309 Joseph Campau Ave., Detroit 12
Kullman, Harold J.....Vet. Admin. Hosp., Dearborn
Kuran, Lionel V.....14853 Michigan, Dearborn
Kurcz, Jos. A.....7433 Michigan Ave., Detroit 10
Kurtz, Irvin J.....25210 Grand River, Detroit 40
Kurtzman, Raymond S.....Detroit Memorial Hosp., Detroit 26
Kutsche, John D.....3794 Fort St., Trenton
Kvietys, Benj.....27235 Joy Rd., Dearborn
Kwasiborski, S. A.....2300 Oak St., Wyandotte

Laberge, James M.....100 Oak, Wyandotte

Lackey, Lawrence S.....525 Visger, Ecorse
Laderach, David C.....1704 Iroquois, Detroit 14
La Ferte, Alfred D. (L).....520 St. Clair, Grosse Pte 30
Laham, M. M.....2929 Fort St., Wyandotte
Lahood, Michael J.....20001 Greenfield, Detroit 35
Laige, Raymond J.....P.O. Box 1259, Detroit 31
Lajoie, Louis J.....601 Piquette, Detroit 2
Lakatos, George C.....33000 Palmer, Wayne
Lake, Robt. C.....8445 E. Jefferson, Detroit 14
Lakin, Alan C.....10326 W. Seven Mile Rd., Detroit 21
Lakin, Mervyn H.....17555 James Couzens, Detroit 35
Lakoff, Chas. B. (L).....10234 W. Seven Mile Rd., Detroit 21
Lam, Conrad R.....28130 Westbrook Ct., Farmington
Lamberson, Frank A.....19001 Grand River, Detroit 23
Lammy, James V.....748 Dav. Whitney Bldg., Detroit 26
Lamont, Richard L.....3815 Pelham Rd., Dearborn
Lamontagne, Gaetan.....14801 Southfield, Allen Park
Lampman, Harold H.....3011 W. Grand Blvd., Detroit 2
Landers, James W.....1401 Rivard, Detroit 7
Landers, Maurice B.....275 W. Grand Blvd., Detroit 16
Lang, Ernst F.....Harper Hospital, Detroit 1
Lange, Wm. A.....1041 Cadieux Rd., Grosse Pointe 30
Langston, John D.....1420 St. Antoine St., Detroit 26
Laning, Geo. M. (L).....R. D. Morey Rd., Sharon, Conn.
Lansing, Eugene H.....33020 Palmer Rd., Wayne
Lansky, Mandell.....16339 E. Warren, Detroit 24
Large, Alfred M.....701 Dav. Whitney Bldg., Detroit 26
Largo, Donald J.....16717 Warwick, Detroit 19
Larkin, Duane R.....28435 Plymouth, Livonia
Larned, Richard I.....15208 Bringard, Detroit 5
Larsen, Edward G.....1803 Trenton Dr., Trenton
Larsen, Robt. D.....76 W. Adams Ave., Detroit 26
Larson, Chas. J.....12729 Cunningham, Wyandotte
Larson, Francine S. (A)....18865 Haggerty Rd., Northville
Larsson, Bror H. (L).....81 E. Kirby Ave., Detroit 2
Lasichak, Andrew G.....76 W. Adams Ave., Detroit 26
Lasley, James W.....1014 David Whitney Bldg., Detroit 26
Latimer, Fredk. R.....28 W. Adams, Detroit 26
Latteier, Karl K.....968 Yarmouth, Birmingham
Lauppe, Edward H.....1553 Woodward Ave., Detroit 26
Lauppe, Fredk. A.....1553 Woodward Ave., Detroit 26
Laura, Albert L.....9105 Harrison, Livonia
Laurisin, Eugene (L).....16554 Muirland, Detroit 21
Lauter, Eric W.....1800 Tuxedo, Detroit 6
Lawand, Frank K.....1077 Fisher Bldg., Detroit 2
Lawhead, Nixon R. (L).....14110 Gratiot Ave., Detroit
Lawrence, Louis F.....17300 Schaefer Rd., Detroit 35
Lawson, James M.....2605 W. Grand Blvd., Detroit 8
Lawson, John W. (A).....98 Hazelwood Ave., Detroit 2
Lazar, Morton R.....20905 Greenfield, Southfield
Leach, David.....3011 W. Grand Blvd., Detroit 2
Leach, Robt. B.....1401 Rivard St., Detroit 7
Leach, Wendell L.....10811 E. Warren, Detroit 1
Leacock, Robt. C.....440 University Pl., Grosse Pointe 30
Leader, Luther R.....801 S. Adams, Birmingham
Leaver, L. Ross.....757 Lakewood Ave., Detroit 15
Lebamoff, Alexander T.....7940 Allen Rd., Allen Park
Lechner, Monroe S.....22770 Kelly Rd., East Detroit
Lecklider, A. F. (R).....848 Berkshire Rd., Grosse Pte 30
Lee, Edith J.....2424 Puritan, Detroit 21
Lee, Frank.....501 Meadowlane Dr., Dearborn
Lee, Harry E. (L).....13616 Gratiot Ave., Detroit 5
Lee, Pyong Tai.....26559 Grand River, Detroit 40
Lehmann, Robert N.....26029 W. Five Mile Rd., Detroit 39
Leipsitz, Louis S.....3566 Cass Ave., Detroit 1
Leiter, Forrest C.....2355 Monroe, Dearborn
Leithauser, Danl. J. (L).....18412 Mack, Detroit 36
Leland, Solomon.....6563 Grand River, Detroit 8
Lemley, Clark F.....3011 W. Grand Blvd., Detroit 2
Lemmer, John A.....6609 Van Dyke, Detroit 13
Lemmon, Chas. E. (L).....1337 Dav. Whitney Bldg., Detroit 26
Lemon, Bruce K.....20905 Greenfield, Southfield
Lentine, James J.....15831 Mack Ave., Detroit 24
Lenz, Willard R.....418 Moran Rd., Detroit 36
Lenzo, Joseph E.....951 E. Lafayette, Detroit 7
Lepard, Cecil W.....1553 Woodward Ave., Detroit 26
Lepley, Fred O. (L).....19799 Mack Ave., Grosse Pte. Wds.
Lepley, Frederick J.....19803 Mack, Grosse Pte. 36
Lerman S. I.....18330 Parkside, Detroit 21
Lerner, Leonard H.....7310 W. Seven Mile Rd., Detroit 21
Lesesne, John M.....17700 Mack Ave., Grosse Pointe 24
Leslie, C. G.....8401 Woodward, Detroit 2
L'Esperance, Simon P. (R)....Rt. 3, Woodslee, Ont., Canada
Lessem, David.....12759 Vernon, Huntington Woods
Leszynski, Jos. S. (L).....10 Peterboro St., Detroit 1
Leucutia, Traian (L).....10 Peterboro, Detroit 1
Levagood, Floyd B.....14056 Artesian, Detroit 23
Levant, Arthur B.....15715 E. Warren, Detroit 24
Levenson, Malcolm L.....24500 Curtis, Southfield
Leventer, Ira.....20211 Ann Arbor Trail, Dearborn
Levick, Walter G.....19959 Vernier, Harper Woods
Levin, David M. (A).....6901 E. 3rd St., Tucson, Ariz.
Levin, Herbert G.....17300 Schaefer, Detroit 35
Levin, M. Mitchel.....20905 Greenfield, Southfield
Levin, S. J.....3011 W. Grand Blvd., Detroit 2
Levine, Edward E.....12891 Sherwood, Huntington Woods
Levine, Sydney S.....8233 W. Chicago Blvd., Detroit 4
Levitt, Irving.....24535 N. Carolina, Southfield
Levitt, Nathan.....607 Kales Bldg., Detroit 26
Levy, David B.....29586 Fenkell, Livonia
Levy, Marvin B.....23200 Woodward Ave., Ferndale
Levy, Stanley H.....10601 Seven Mile Rd., Detroit 21
Lewin, Harry (L).....10 Peterboro, Detroit 1
Lewis, Benjamin M.....1401 Rivard, Detroit 7
Lewis, Chas. T. (L).....5050 Joy Rd., Detroit 4
Lewis, Harvey Y.....14434 W. McNichols Rd., Detroit 35
Lewis, J. Hugh.....1543 Ford Ave., Wyandotte
Lewis, Lee A.....2730 E. Jefferson Ave., Detroit 7
Lewis, Robt. H.....14807 W. McNichols, Detroit 35
Lewis, Wilfrid J.....10 Peterboro St., Detroit 1
Libbrecht, Robt. V.....6540 Park Ave., Allen Park
Lichter, Max L.....2900 Oakwood Blvd., Melvindale
Lichty, Dorman E.....7701 Wyoming, Dearborn
Liddicoat, Arthur G.....20125 Fenkell, Detroit 23
Lieberman, Barnard L.....19212 Woodward Ave., Detroit 3
Lightbody, James J.....1553 Woodward Ave., Detroit 26
Lignell, Rudolph W...401 Northland Med. Bldg., Southfield
Lilly, Robert P.....29594 W. Five Mile Rd., Livonia
Lindner, David W.....801 Dav. Whitney Bldg., Detroit 26
Linkner, Leonard S.....12944 La Salle Lane, Huntington Woods
Lipinski, Stanley L.....7540 Michigan Ave., Detroit 10
Lipkin, Ezra.....5715 Michigan Ave., Detroit 10
Lipnik, Carl E.....31610 Plymouth Rd., Livonia
Lipnik, Morris J.....17000 W. Eight Mile, Southfield
Lipschutz, Louis S.....19750 Chesterfield Rd., Detroit 21
Lipson, Channing T.....16815 James Couzens, Detroit 35
Lipson, Madeleine L.....1800 Tuxedo, Detroit 6
Lipton, Raymond F.....10 Peterboro St., Detroit 1
Litsky, Abraham D.....1183 E. Grand Blvd., Detroit 11
Little, James W.....3637 Franklin Rd., Bloomfield Hills
Litwin, Jack A.....15121 W. McNichols Rd., Detroit 35
Litzenberger, D. J.....1386 E. Grand Blvd., Detroit 11
Livingood, Clarence S.....345 University, Grosse Pte. 30
Lloyd, James R.....1515 Dav. Whitney Bldg., Detroit 26
Lo, Lien Fu.....1800 Tuxedo, Detroit 6
Lockhart, Edward C.....5005 Tireman, Detroit 4
Lockwood, Bruce C. (L)....19490 Parkside Ave., Detroit 21
Lofstrom, James E.....1420 St. Antoine St., Detroit 26
Logrippo, Annie B.....Henry Ford Hosp., Detroit 2
Lohmann, Carl W.....1229 Dav. Whitney Bldg., Detroit 26
London, Berton L.....18510 Meyers, Detroit 35
Long, Earl C. (L)....19751 James Couzens Hwy., Detroit 35
Long, John J.....15901 Greenfield Ave., Detroit 27
Longo, Salvatore.....468 Cadieux, Detroit 30
Loomus, Gerald N.....4100 W. McNichols, Detroit 21
Lopatin, Reuben.....1800 Tuxedo, Detroit 6
Loranger, C. B. P.....20825 Mack, Detroit 36
Loranger, Guy L.....34 Moross Rd., Detroit 36
Lorber, Jos. H.....873 Lakewood Ave., Detroit 15
Lorentzen, Edwin H. (L).....11702 Grand River Ave., Detroit 4
Lovas, Wm. S.....6354 W. Fort St., Detroit 9
Love, Donald M.....703 Parker, Apt. 4, Detroit 14
Love, W. Thos.....231 E. Warren Ave., Detroit 1
Lowe, Adolf W.....3338 W. Davision Ave., Detroit 38
Lowinger, Paul L.....951 E. Lafayette, Detroit 7
Lowrie, Wm. L.....2799 W. Grand Blvd., Detroit 2
Luby, Elliot D.....19680 Roslyn Rd., Detroit 21
Lucas, Robert J.....771 Fisher Bldg., Detroit 2

Lui, Alfred H. F.....Wayne Co. Gen. Hospital, Eloise
Lumpkin, John G., Jr.....243 E. Warren Ave., Detroit 1
Lutz, Earl F.....13 211 Gen. Mtrs. Bldg., Detroit 2
Lutz, Sherwin J.....15121 W. McNichols, Detroit 35
Luz, Denis A.....Detroit Memorial Hosp., Detroit 26
Luzadre, John H.....18430 Mack Ave., Detroit 36
Lynn, David H.....Lynn Hospital, Lincoln Park
Lynn, Harvey D.....3815 Pelham Rd., Dearborn
Lytle, Robt. P.....402 Northland Med. Bldg., Southfield

Maben, Hayward C., Jr. (A).....400 East 33rd St., Chicago, Ill.
Mabley, John D.....1037 David Whitney, Detroit 26
MacCraken, F. L. (A)....Dekoven Foundation, Racine, Wis.
MacDougall, Orrin P.....13700 Woodward Ave., Detroit 3
MacFarlane, Howard W.....1553 Woodward Ave., Detroit 26
MacGregor, Wm. W. (L)..6320 W. Surrey St., Birmingham
Mack, Harold C.....3011 W. Grand Blvd., Detroit 2
Mack, Robert E.....Woman's Hospital, Detroit 1
MacKenzie, Earl D.....81 E. Kirby St., Detroit 2
MacKenzie, John W. (L).....289 Rivard Blvd., Grosse Pointe 30
Mackersie, Wm. G. (L)....18205 Roselawn Ave., Detroit 21
Mackler, Harry S.....1800 Tuxedo, Detroit 6
MacLeod, Chas. W.....16345 W. McNichols, Detroit 35
Macmillan, Francis B.....1553 Woodward Ave., Detroit 26
MacPherson, K. C. (L).....8100 E. Jefferson, Detroit 14
MacQueen, Malcolm D. (L).....660 Woodward Ave., Detroit 26
Maczewski, John E.....24735 Van Dyke, Centerline
Mader, Ivan J.....26111 Woodward Ave., Huntington Wds.
Magnell, Ralph C.....8825 Puritan Ave, Detroit 38
Maguire, Clarence E.....1553 Woodward Ave, Detroit 26
Mahanti, Biresh C.....2331 Van Alstyne, Wyandotte
Mahlin, Murray S.....16820 Greenfield Ave., Detroit 35
Mahoney, Hugh M.....1553 Woodward Ave., Detroit 26
Maibauer, Fredk. P.....2934 Biddle Ave., Wyandotte
Mainwaring, Rosser L.....1910 Russell, Dearborn
Mainzer, Jacob.....36475 Five Mile Rd., Livonia
Maire, Edward D.....15224 E. Jefferson, Detroit 30
Maitland, Ruth J.....Mich. Bell Telephone, Detroit 26
Majauskas, V. E.....23738 Joy Rd., Detroit 39
Majzoub, Ahmad J.....3334 Fort, Lincoln Park
Malina, Stephen.....1601 Kirkway Dr., Rt. 3, Bloomfield Hills
Malje, Frank J.....Garden City Clinic, Garden City
Malone, John M.....17300 Schaefer Rd., Detroit 35
Malone, Robert J.....15101 Southfield, Allen Park
Maloney, John A.....670 Maccabees Bldg., Detroit 2
Maloney, Philip J.....16401 Grand River, Detroit 27
Maltzer, Jos. H.....26505 John R, Madison Heights
Mammel, Bernard T.....14447 W. Seven Mile Rd., Detroit 35
Mandel, Leslie.....14444 W. McNichols Rd., Detroit 35
Mandell, Gerald H.....Sinai Hospital, Detroit 35
Mandiberg, Jack N.....12700 W. 7 Mile Rd., Detroit 35
Mann, Andrew D.....20901 Moross, Detroit 36
Manning, Morey H.....950 E. State Fair Ave., Detroit 3
Manson, Gordon.....Henry Ford Hosp., Detroit 2
Mapletoft, Kenneth E.....420 Mohawk, Dearborn
Marcus, Edwin L.....15101 Southfield, Allen Park
Marecki, Vincent J.....10326 W. Warren, Dearborn
Margules, Saul Z.....11846 E. McNichols, Detroit 5
Marinus, Carleton J. (L).....1553 Woodward Ave., Detroit 26
Mark, Jerome.....513 David Whitney Bldg., Detroit 26
Markey, Alexander P.....14853 Michigan Ave., Dearborn
Markey, Frank R.....17174 Fairfield, Detroit 21
Markoe, Rupert C. L.....7600 John R St., Detroit 2
Marks, Ben.....232 W. Grand River Ave., Detroit 26
Marks, Bert W.....8250 Lincoln Dr., Huntington Woods
Marsh, Alton R.....15696 Woodland Dr., Dearborn
Marshall, James R.....14827 E. Jefferson Ave., Detroit 15
Marshall, J. R., Jr.....20160 Mack Ave., Detroit 36
Martin, J. B., Jr.....449 E. Elizabeth St., Detroit 1
Martin, Lyndle R.....2000 Second Blvd., Detroit 26
Martin, Peter A.....857 Fisher Bldg., Detroit 2
Martin, Walter.....17523 DeQuinder, Detroit 12
Martin, Wilbur C.....2536 W. Grand Blvd., Detroit 6
Martineau, Perry C.....16709 Glastonbury, Detroit 19
Martinez, Pedro O.....1439 Bagley Ave., Detroit 16
Martmer, Edgar E.....693 Washington Rd., Grosse Pointe 30
Marvin, Robert C.....1678 Marriman Rd., Wayne
Marwil, Thos. B.....17563 Greenfield Rd., Detroit 35
Mateer, John G. (L).....Henry Ford Hospital, Detroit 2
Matthews, Burton V.....13724 W. Fort St., Southgate
Mattman, Paul E.....1500 Seminole, Detroit 14
Mattson, Theo. M.....2730 Maybury Grand, Detroit
Mauch, Eugene W.....15101 Southfield, Allen Park
Mauthe, Harry G.....16859 Pollyana Dr., Livonia
Maynard, Fredk. M.....6828 Park Ave., Allen Park
McAlonan, William T. (L).....10 Peterboro St., Detroit 1
McAlpine, Gordon S. (L)....3011 W. Grand Blvd., Detroit 2
McBryan, Thos. J.....Grace Hosp., Detroit
McCadie, James H.....13700 Woodward Ave., Highland Park 3
McCandless, Virginia.....2355 Monroe, Dearborn
McCaughey, R. S.....Wayne St. University, Detroit 7
McClellan, Robt. J.....16345 W. McNichols, Detroit 35
McClelland, Rachel L.....33026 Five Mile Rd., Livonia
McClendon, James J.....8401 Woodward, Detroit 2
McClintock, John J. (L).....16151 Schoolcraft Ave., Detroit 27
McClure, Robt. W.....9111 E. Outer Dr., Detroit 13
McClure, Wm. R. (L).....Box 1498, Boynton Beach, Fla.
McCole, C. E.....Henry Ford Hospital, Detroit 2
McColl, Chas. W.....2025 Ford Ave., Wyandotte
McColl, Clarke M.....2799 W. Grand Blvd., Detroit 2
McCollum, E. Bert.....1553 Woodward Ave., Detroit 26
McCord, Carey P. (L)....Sch. of Public Health, Ann Arbor
McCormick, Colin C.....24352 Rockford Ave., Dearborn
McCue, Francis B.....6742 Park Ave., Allen Park
McCullough, L. E.....1711 David Whitney Bldg., Detroit 26
McDonald, Angus L. (L).....15125 Gratiot, Detroit 5
McDonald, John R.....Harper Hosp., Detroit 6
McDonald, Wm. G.....15600 Michigan Ave., Dearborn
McEvitt, Wm. G.....1140 W. Boston Blvd., Detroit 2
McFayden, Hugh A. (L).....10 Peterboro St., Detroit 1
McGee, T. Manford.....(Address Unknown)
McGillicuddy, W. E. (R).....7542 Pinehurst, Dearborn
McGinnis, Kenneth D.....Henry Ford Hospital, Detroit 2
McGlaughlin, N. D.....2312 Biddle Ave., Wyandotte
McGough, Jos. M.....18716 Grand River, Detroit 23
McGuire, John F.....610 Northland Med. Bldg., Southfield
McHenry, John T.....1401 Rivard St., Detroit 7
McIntosh, Robt. D.....6307 W. Fort St., Detroit 9
McIntvre, Wm. B.....1145 David Whitney Bldg., Detroit 26
McKean, G. Thos.....1553 Woodward Ave., Detroit 26
McKeever, Geo. E.....5237 Oakman Blvd., Dearborn
McKenna, Chas. J.....14618 E. 7 Mile, Detroit 5
McKnight, Robt. E.....20905 Greenfield, Southfield
McLane, Harriet I. E. (L).....4350 Oregon Ave., Detroit 4
McLaurin, Jasper E.....9036 Dexter Blvd., Detroit 6
McLean, Brita R.....1365 Cass, Detroit 26
McLean, Don W.....1066 Fisher Bldg., Detroit 2
McLean, Donald C.....10 Peterboro, Detroit 1
McNamara, Joseph M.....9430 S. Main, Plymouth
McNeill, Roger F.....119 Kercheval, Grosse Pointe
McNichol, L. J.....18424 W. McNichols Rd., Detroit 19
McPhee, Roderick T.....21503 Harper, St. Clair Shores
McPherson, Robt. J. (L).....12626 Meyers Rd., Detroit 27
McQuiggan, Mark R.....700 Seward, Detroit 2
Medalie, Morris.....1800 Tuxedo, Detroit 6
Meek, Stuart F.....13020 Kilbourne, Detroit 13
Meghnot, Parviz.....1800 Tuxedo, Detroit 6
Melander, L. W., Jr.....1229 David Whitney Bldg., Detroit 26
Mellen, Hyman S.....16800 Greenfield, Detroit 35
Mellinger, Raymond C.....959 Pemberton, Grosse Pointe
Melnik, Maxim P.....3011 W. Grand Blvd., Detroit 2
Melnyczuk, Nestor.....7304 Michigan, Detroit 10
Menagh, Frank R. (L).....4010 Columbus Ave., Detroit 4
Mendelson, Charles G.....Henry Ford Hospital, Detroit 2
Mendelson, Herbert.....15200 Northfield, Oak Park 37
Mendelssohn, Reuben J.....14427 Mack Ave., Detroit 15
Mendians, Edgar V.....9486 Beaconsfield, Detroit 24
Mendoza, Saml.....6356 Michigan, Detroit
Menton, Norman J.....15300 W. McNichols, Detroit 35
Merkel, Chas. C.....85 Kercheval Ave., Grosse Pointe Farms
Merkle, Karl.....530 N. Telegraph, Dearborn
Merrill, C. R., Jr.....1951 Monroe, Dearborn
Merritt, Earl G.....10 Peterboro St., Detroit 1

Mersky, Charlotte I. (A)....32215 Queensboro, Farmington
Metes, John S.....62 Webber Pl., Grosse Pointe Shores
Metzger, Harry C.....25504 Wareham, Huntington Woods
Meyer, Eugene (A).....17041 Pinecrest Dr., Allen Park
Meyer, John S.....Wayne State Univ., Detroit 7
Meyer, Kenneth R.....Oakwood Hosp., Dearborn
Meyers, Marjorie P.....5320 John R St., Detroit 2
Meyers, Maurice P.....18984 Livernois, Detroit 21
Meyers, Solomon G.....966 Fisher Bldg., Detroit 2
Michael, Michael J.....703 Mutual Bldg., Detroit 26
Mihay, Benjamin.....2021 Monroe, Dearborn
Mikesell, W. B., Jr.....23611 Goddard, Taylor
Milad, Avis A.....15121 W. Seven Mile Rd., Detroit 35
Mileris, Vytautas.....2730 E. Jefferson Ave., Detroit 7
Millard, Glenn E.....958 Fisher Bldg., Detroit
Miller, Danl. H.....23100 Cherry Hill, Dearborn
Miller, Elmer B.....20 Oxford Rd., Pleasant Ridge
Miller, Jacob J.....20131 James Couzens, Detroit 35
Miller, J. Martin.....2799 W. Grand Blvd., Detroit 2
Miller, Karl L.....1553 Woodward Ave., Detroit 26
Miller, Myron H.....27330 Southfield Rd., Lathrup Village
Miller, Oscar W.....Fleetwood Plant, FBD, GMC, Detroit 9
Miller, Thos. H.....1305 David Whitney Bldg., Detroit 26
Miller, Wm. E. (L).....10 Peterboro, Detroit 1
Miller, William J.....5649 Inkster Rd., Garden City
Millman, Jerome I.....St. Mary's Hospital, Livonia
Mills, Clinton C.....16190 Jas. Couzens Hwy., Detroit 21
Mills, Geo. R.....8209 Allen Rd., Allen Park
Milton, S. Byron.....26560 W. Outer Dr., Lincoln Park
Mintz, Edward I.....954 Fisher Bldg., Detroit 2
Mintz, Morris J.....16895 Livernois St., Detroit 21
Minui, Morteza.....1144 Carlson, Wayne
Miral, Solomon P.....4825 E. McNichols Rd., Detroit 12
Mishelevich, Sophie (L).....4651 E. Nine Mile Rd., Warren
Miskinis, Martyna.....393 W. Grand Blvd., Detroit 16
Missavage, Edward, Jr.....Wayne Co. Gen. Hosp., Eloise
Mitchell, A. W.....12000 Visger, Detroit
Mitchell, C. Leslie.....Henry Ford Hospital, Detroit 2
Mitchell, Darnell P.....8401 Woodward Ave., Detroit 2
Mitchell, Ralston S.....243 E. Warren, Detroit 1
Mitchell, Roy A.....Det. Memorial Hosp., Detroit 26
Moehlig, Robt. C. (L).....3001 W. Grand Blvd., Detroit 2
Moghissi, Kamran S...763 David Whitney Bldg., Detroit 26
Mogill, Geo.....3150 Second Blvd., Detroit 1
Moisides, Vasil P. (L).....28 W. Adams Ave., Detroit 26
Moll, Clarence D.....10 Peterboro St., Detroit 1
Molnar, Stephen K.....4525 S. Telegraph Rd., Dearborn
Molner, Jos. G.....14890 Glastonbury Rd., Detroit
Momcilovich, Boxidar.....2241 Huron River Dr., Rockwood
Mond, Edward.....10 Witherell St., Detroit 26
Monson, Robt. C.....17520 Chester, Detroit 24
Montante, Jos. R.....18715 Bretton Dr., Detroit 23
Montenegro, Milton....24224 W. Seven Mile Rd., Detroit 19
Montgomery, Wm. C.....25717 Coolidge, Oak Park 37
Monto, Raymond W.....Henry Ford Hospital, Detroit 2
Moore, John W., Jr.....8425 W. Eight Mile Rd., Detroit 21
Moore, Warren R.....17800 E. 8 Mile Rd., Detroit 36
Mopper, Coleman.....14633 E. Seven Mile Rd., Detroit 5
Moran, Frank J.....27459 Five Mile Rd., Livonia
Morand, Louis J. (A).....18944 Fairfield, Detroit 21
Morgan, Donald N.....1553 Woodward Ave., Detroit 26
Morgan, Philip J.....Detroit Memorial Hosp., Detroit 26
Moriarty, Geo. J.....3011 W. Grand Blvd., Detroit 2
Morita, Yoshikazu.....26111 Woodward Ave., Huntington Woods
Morley, Arthur R.....15753 Promenade, Allen Park
Morley, George M.....12922 W. Warren, Dearborn
Morley, Harold V.....970 Fisher Bldg., Detroit 2
Morley, James A. (L).....10514 Plymouth Ave., Detroit 4
Moroun, Sheffick J.....675 Parker, Detroit 14
Morris, Harold L. (L).....3001 W. Grand Blvd., Detroit 2
Morrison, George W.....2033 Park, Detroit 26
Morse, William H.....19203 Grand River, Detroit 23
Morton, David G.....19445 Plymouth, Detroit 28
Moscovic, Edward A.....Oakwood Hospital, Dearborn
Mosee, Wm. J.....9219 Dexter, Detroit 6
Moseley, Fredk. L.....2561 S. Schaefer, Detroit
Mosen, Max M.....8015 Harper Ave., Detroit 13
Moser, Peter F.....26151 Huron River Dr., Flat Rock
Moses, John W.....754 Fisher Bldg., Detroit 2
Moss, Ervin B. (A).....23295 Kipling, Oak Park
Moss, Nathan H.....2847 Trumbull, Detroit 16
Moss, Norman D.....25415 Southfield Rd., Southfield
Moss, Selma S.....20905 Greenfield, Southfield
Moszczynski, B. J.....1113 David Whitney Bldg., Detroit 26
Mott, Carlin P. (L).....2395 W. Grand Blvd., Detroit 8
Mott, Fredk. D.....6533 E. Jefferson, Detroit 7
Moynihan, John W.....2841 Monroe Blvd., Dearborn
Mozen, Herschel E.....12950 W. Chicago Ave., Detroit 28
Mucasey, John.....21415 W. 8 Mile Rd., Detroit 19
Muirhead, Ernest E.....432 E. Hancock, Detroit 1
Mullen, Jos. R.....19003 Ecorse Rd., Allen Park
Munson, Henry T.....18350 Mack, Grosse Pointe 36
Murphy, Donald J. (A).....Virginia Mason Hosp., Seattle, Wash.
Murphy, Scipio G.....603 E. Forest, Detroit 1
Murphy, Wm. M.....10500 E. Warren Ave., Detroit 14
Murray, Gordon M.....9901 Whittier, Detroit 24
Murray, Robt. J.....3700 West Rd., Trenton
Murray, Thomas H. (A).....25239 Southfield, Southfield
Muske, Paul H.....13244 W. Warren, Dearborn
Myers, Danl. W.....1150 Bedford Rd., Detroit 30
Nagle, John W. (L).....114 Maple St., Wyandotte
Nahigian, Russell.....17371 Annchester Ave., Detroit 19
Nahoum, Antoine.....1030 Kensington, Detroit 30
Nash, Edward B.....4075 Inkster Rd., Inkster
Naud, Henry J.....18456 Grand River Ave., Detroit 23
Naud, Joseph H.....412 David Whitney Bldg., Detroit 26
Navori, Cornelius A.....3516 Fort St., Lincoln Park
Naylor, Arthur H. (A).....10033 Tireman, Dearborn
Neeb, Walter G.....16840 E. Warren St., Detroit 24
Nehra, John M.....320 E. Center Prof. Bldg., Detroit 36
Neill, Edwin J.....8045 E. Jefferson St., Detroit 14
Nelson, Darwin M.....63 Ridge Rd., Detroit 36
Nelson, Harry M.....3001 W. Grand Blvd., Detroit 2
Nelson, Norman A.....Wayne Co. Gen. Hosp., Eloise
Nelson, Victor E.....3025 Crooks Rd., Royal Oak
Nesbit, Warren S.....474 Fisher Bldg., Detroit 2
Neufeld, Paul N.....19467 Livernois, Detroit 21
Newby, Burns G.....20905 Greenfield, Southfield
Newman, Ernest.....17371 Evergreen St., Detroit 19
Newman, Geo. F.....2021 Monroe Blvd., Dearborn
Newman, Max K.....16861 Wyoming Ave., Detroit 21
Newton, Kenneth.....11841 Susan Ave., Warren
Nichols, Wallace, Jr.....3631 S. Longmeadow, Trenton
Nickel, Warren O.....861 Monroe, Dearborn 8
Nickels, Albert W.....3011 W. Grand Blvd., Detroit 2
Nielsen, Aage E.....320 Professional Bldg., Detroit 1
Nielsen, Donald R.....26339 Woodward Ave., Huntington Woods
Nigro, Norman D.....7815 E. Jefferson, Detroit 14
Nill, John B.....15001 E. Warren, Detroit 24
Nill, Wm. F. (L).....15001 E. Warren, Detroit 24
Noble, Wm. C.....4045 W. Jefferson, Ecorse 29
Noe, Jos. T., Jr.....Wyandotte Chem. Corp., Wyandotte
Nolan, Bernard E.....5460 Schaefer Rd., Dearborn
Nolting, Wilfred S. H.....15850 E. Warren Ave., Detroit 24
Northcross, David C.....2929 W. Boston Blvd., Detroit 6
Norton, Arthur B. (L).....1077 Fisher Bldg., Detroit 2
Noshay, Wm. C.....2799 W. Grand Blvd., Detroit 2
Novack, Richard L.....15930 Shadyside, Livonia
Novy, Robt. L. (L).....858 Fisher Bldg., Detroit 2
Nowosielski, P. F.....15256 Levan Rd., Livonia
Nunn, James W.....106 W. Davison, Detroit 3
Nyboer, Jan.....Harper Hospital, Detroit 1
O'Brien, Geo. M.....2501 W. Grand Blvd., Detroit 8
Obushkevich, Leon S. (A).....15720 W. Warren, Detroit 28
O'Connor, Katheryn L.....17711 Schoolcraft, Detroit 27
O'Donnell, Dayton H.....2501 W. Grand Blvd., Detroit 8
Oetting, Edward M.....2923 Iroquois Ave., Detroit 14
O'Gawa, Gilbert M. (M).....Bethesda Naval Hosp., Bethesda, Md.
Ohmart, Galen B.....8721 E. Jefferson Ave., Detroit 14
Ohrt, Harold F. (A).....285 E. Grand Blvd., Detroit 7
Okun, Milton H.....3261 Sherbourne Rd., Detroit 21
Oldford, Joseph R.....17000 W. 8 Mile Rd., Detroit 35
Olejniczak, Stanley.....Wayne Co. Gen. Hosp., Eloise
Olen, Alex.....13100 Harper Ave., Detroit 13
O'Linn, Francis P.....1055 Fisher Bldg., Detroit 2
Olmsted, Geo. S.....27305 Southfield Rd., Lathrup Village
Olson, Avis M.....Mt. Carmel Mercy Hosp., Detroit 35

Olson, Donald T.....17701 W. McNichols Rd., Detroit 35
Olson, James A.....17000 West 8 Mile Rd., Southfield
Oppenheim, Jos. M.....24091 Dante, Oak Park 37
Organ, Fred W. (L).....1 Calvert, Detroit 2
Ormond, Robt. S.....1951 Monroe St., Dearborn
O'Rourke, Paul V.....2635 Woodstock, Detroit 3
O'Rourke, Randall M.....7384 12th St., Detroit 6
Osius, Eugene A.....8120 E. Jefferson Ave., Detroit
Ostrowski, Arthur Z...610 Northland Med. Bldg., Southfield
Otlewski, Eugene A.....20905 Greenfield, Southfield
Ottaway, John P.....18226 Mack Ave., Grosse Pointe Farms
Otto, Donald.....Det. Memorial Hospital, Detroit 26
Owen, Clarence I.....2689 Dupont, Jacksonville, Fla.
Palmer, Alice E. (A).....USOM Ph. APO 143, San Francisco, Calif.
Palmer, Milton R.....8700 Dexter Blvd., Detroit 6
Palmisano, I. J.....25447 Plymouth Rd., Detroit 39
Panczak, Tamara.....Plymouth State Hosp., Northville
Pangburn, Leon E. (L).....12897 Woodward, Detroit 3
Panic, Stephen M.....1001 W. Seven Mile, Detroit 3
Pantos, Theo. G.....1536 David Whitney Bldg., Detroit 26
Parfanowycz, S. N. (A).....3347 Grant St., Detroit 12
Parker, Albert R.....3720 Washington St., Wayne
Parker, Benj. R.....19149 W. Seven Mile Rd., Detroit 19
Parnell, John W.....21 Whitcomb Dr., Grosse Pointe Farms
Parr, Robt. W. (A)....1126 Audubon Rd., Grosse Pointe 30
Parrish, Rufus H. (A).....2610 Starlevant, Detroit
Pasternacki, N. T.....6203 Chene St., Detroit 11
Pastorius, Melvin K.....5947 Middlesex, Dearborn 1
Patton, Roy B.....Henry Ford Hospital, Detroit 2
Paul, Lloyd J.....19321 Greenfield, Detroit
Pawlowski, Jerome I.....2009 E. Grand Blvd., Detroit 11
Payne, Eugene H. (R).....Box 1299, Hammond, La.
Payne, Walter A., Jr.....357 Hillcrest, Grosse Pointe 36
Paysner, Harry A.....13700 Woodward Ave., Highland Park 3
Pearce, Arthur J.....15317 Piedmont St., Detroit 23
Pearlman, Jack.....25860 Concord, Huntington Woods
Pearse, Harry A.....17000 W. Eight Mile, Southfield
Peat, Alexander C.....1350 Devonshire Rd., Grosse Pointe Park
Pedersen, Herbert E.....3815 Pelham Rd., Dearborn
Peggs, Geo. F.....5419 Livernois Ave., Detroit 10
Pendy, Geo. V.....1001 David Whitney Bldg., Detroit 26
Pendy, John M.....1001 David Whitney Bldg., Detroit 26
Penner, David A.....18530 Grand River Ave., Detroit 23
Pensler, Leslie.....10151 Michigan, Dearborn
Pensler, Meyer.....10149 Michigan Ave., Dearborn 2
Percy, Donald F.....15901 Greenfield Ave., Detroit 27
Perdue, Grace M.....3011 W. Grand Blvd., Detroit 2
Perez Borja, C. M. (A).....Receiving Hospital, Detroit
Perkin, Frank S.....3011 W. Grand Blvd., Detroit 2
Perlis, Hyman L. (L).....10 Peterboro, Detroit 1
Perlis, Marvin S.....1030 Fisher Bldg., Detroit 2
Perry, Joseph H.....259 Lewiston Rd., Grosse Pointe 36
Peterman, Earl A.....13700 Woodward, Highland Park 3
Peters, Wm. R.....12400 E. Seven Mile Rd., Detroit 5
Peterson, Gustav.....Fisher Body, Willow Run, Ypsilanti
Peterson, Robert A.....17581 Prest, Detroit 35
Petix, Samuel C.....19207 Schaefer, Detroit 35
Petoskey, Edward A.....5656 W. Fort, Detroit 9
Petrick, Thos. J.....15101 Southfield, Allen Park
Petrini, Mario A.....1080 Fisher Bldg., Detroit 2
Petty, Thos. A.....1204 Yorkshire Rd., Detroit 30
Petz, Arthur John.....15420 Farmington, Livonia
Petz, Thomas J.....1139 David Whitney Bldg., Detroit 26
Peven, Philip S.....18709 Meyers Rd., Detroit 35
Phillips, Burton E.....5050 Joy Rd., Detroit 4
Picard, Jos. D.....5237 Oakman Blvd., Dearborn
Piccone, Louisa I.....17700 W. Warren, Detroit 28
Pichette, J. Walton.....6650 Greenfield Rd., Dearborn
Pickard, Orlando W. (L)..14300 W. McNichols, Detroit 35
Pierce, James M., Jr.....Wayne St. University, Detroit 7
Pietra, A. W.....10338 Joseph Campau, Detroit 12
Pinckard, Karl G. (L).....5805 Evergreen, Dearborn 6
Pink, Rose M.....11413 Joseph Campau, Detroit 12
Pinney, Lyman J. (L).....28 W. Adams, Detroit 26
Pino, Ralph H. (L).....48151 W. Ann Arbor Rd., Plymouth
Piper, Ralph R.....1495 McKinstry, Detroit 9
Pittman, John E. (L).....1553 Woodward Ave., Detroit 26
Pitts, Kenneth E.....17850 Maumee, Grosse Pointe
Platz, Carol K.....612 Est. Cen. Prof. Bldg., Detroit 36
Pliskow, Harold.....10730 W. Seven Mile Rd., Detroit 21
Plotnick, Harold.....18654 Muirland, Detroit 21
Plous, Eugene I.....569 Fisher Bldg., Detroit 2
Podolsky, Harold M.....3755 Fort, Lincoln Park
Pogrebniak, A.....25210 Grand River, Detroit 40
Poim, Senta V.....10 Peterboro, Detroit 1
Polentz, Chas. P.....Medical Concourse N. C., Southfield
Polk, John E.....8742 12th St., Detroit 6
Pollack, Jerome L.....14551 Southfield, Allen Park
Pollack, John J.....18200 Wyoming, Detroit 21
Pollard, R. J.....Grace Hosp., Detroit 1
Pollens, Louis S.....12730 W. McNichols Rd., Detroit 35
Pollina, Clement J.....21503 Harper, St. Clair Shores
Ponka, Jos. L.....2799 W. Grand Blvd., Detroit 2
Pool, Walter D.....20901 Moross Rd., Detroit 36
Poos, Edgar E. (L).....3001 W. Grand Blvd., Detroit 2
Porretta, Chas. A.....507 Northland Med. Bldg., Southfield
Porretta, Francis S.....18591 Saratoga Blvd., Lathrup Village
Porretta, George F.....20905 Greenfield, Southfield
Porter, Dwight H., Jr.....3919 John R St., Detroit 1
Porter, Fredk. G.....29590 Five Mile, Livonia
Porter, Howard J. (A).....2555 S.E. 7th St., Pompano Beach, Fla.
Portnoy, Harry.....18010 Roselawn, Detroit 21
Posch, Jos. L.....1410 Kales Bldg., Detroit 26
Posner, Irving.....18111 Muirland Ave., Detroit 21
Potts, Elihue B.....8943 Twelfth St., Detroit 6
Poznanski, Andrew K.....Henry Ford Hospital, Detroit 2
Prasad, Ananda S.....Wayne State University, Detroit 7
Pratt, Jean P. (L).....18910 Fairway Dr., Detroit 21
Pratt, Lawrence A. (A).....USOM, APO 143, San Francisco, Calif.
Preston, Ruth E.....3011 W. Grand Blvd., Detroit 2
Pribor, Hugo C.....530 New Brunswick Ave., Perth Amboy, N. J.
Price, A. Hazen.....408 David Whitney Bldg., Detroit 26
Price, Alvin E.....1553 Woodward Ave., Detroit 26
Priest, Robt. J.....Henry Ford Hospital, Detroit 2
Primack, Marvin H.....7430 Second, Detroit 2
Prince, Addison E.....8942 Dexter, Detroit 6
Prisbe, Edward J.....16603 Plymouth Rd., Detroit 27
Priver, Julien.....6741 W. Outer Dr., Detroit 35
Procailo, Alexander B.....29901 Ford Rd., Garden City
Proctor, J. Laurence.....6246 Chase Rd., Dearborn
Proctor, Leonard R.....3815 Pelham Rd., Dearborn
Proctor, Lorne D.....Henry Ford Hospital, Detroit 2
Prokop, Frank P.....12740 S. Marrow St., Dearborn
Prokopovich, V.....19666 Conant, Detroit 34
Proskey, Aloysius J. (A).....16167 Glastonbury, Detroit 19
Proud, Robert H.....26151 Huron River Dr., Flat Rock
Proud, Russel F.....26151 Huron River Dr., Flat Rock
Prus, A. Michael.....4160 John R St., Detroit
Prust, Frank W.....1536 David Whitney Blvd., Detroit 26
Prystowsky, S.....1800 Tuxedo, Detroit 6
Pugh, Howard C.....1553 Woodward Ave., Detroit 26
Pugliesi, Angelo.....9489 E. Outer Dr., Detroit 13
Pugliesi, Benedetto.....9489 E. Outer Dr., Detroit 13
Pugliesi, Frank J.....320 Eastland Prof. Bldg., Detroit 36
Pullum, Carla A.....14530 E. Warren Ave., Detroit 15
Purcell, Frank H. (L).....10 Witherell St., Detroit 26
Puro, Henry E.....1733 Trenton Dr., Trenton
Pursel, Stewart E.....307 David Whitney Bldg., Detroit 26
Purves, W. L.....17595 Parkside, Detroit 21
Quigley, Eugene H.....111 Brentwood, Dearborn
Quigley, Wm. G.....1075 Fisher Bldg., Detroit 2
Quinn, Edward L.....1141 Golfview, Birmingham
Quinones, Rafael E.....17200 E. Warren, Detroit 24
Rabinovitch, Bella M.....20133 Marlowe, Detroit 35
Raby, Naim M.....15830 Fort, Southgate
Rachmaninoff, N.....Harper Hospital, Detroit 1
Radgens, Paul D.....Ford Motor Co., Highland Park
Rahm, Lambert P.....14411 E. Jefferson Ave., Detroit 15
Raiford, Frank P. (L).....9310 12th, Detroit
Raiford, Frank P., Jr.....9107 12th Street, Detroit 6
Ralyea, Imbi.....16645 Freeland, Detroit 35
Ramos, Herminio R.....9801 Conant, Hamtramck 12
Ramsey, Robt. H.....3815 Pelham Rd., Dearborn
Randall, David S.....3955 Fort St., Lincoln Park
Rapoport, Bernard.....1800 Tuxedo, Detroit 6
Rapp, Seymour L.....5055 W. Outer Dr., Detroit 35

Raskin, Herbert A.....18510 Meyers Rd., Detroit 35
Raskin, Morris.....15361 Plymouth Rd., Detroit 27
Rastello, Peter B. (R)....3295 West Shore Dr., Orchard Lake
Rattner, Wm. H.....1355 David Whitney Bldg., Detroit
Rau, Fredk. W.....215 Professional Bldg., Detroit 1
Rausch, Nancy H.....11639 Turner, Detroit 4
Raven, Clara.....400 E. Lafayette, Detroit 26
Ravitz, Louis A.....12831 Burton Ave., Oak Park 37
Ray, Kenneth J.....28059 Elba Dr., Grosse Isle
Raynor, Harold F. (L).....49 Virginia Pk., Detroit 2
Razi, Massoud.....1214 S. Wayne, Wayne
Read, Raymond.....Wayne State Univ., Detroit 7
Rebandt, Raymond W.....2615 W. Jefferson, Trenton
Rebuck, John W.....2799 W. Granm Blvd., Detroit 2
Redding, Lowell G.....1336 Southfield Rd., Lincoln Park
Reder, Benjamin.....17301 W. Eight Mile Rd., Detroit 35
Redfern, W. Earl.....2799 W. Grand Blvd., Detroit
Reed, H. Walter (L)..14447 W. Seven Mile Rd., Detroit 35
Reed, Ivor E.....1553 Woodward Ave., Detroit 26
Reed, Joseph O., Jr.....448 Lincoln, Detroit 30
Reed, Melvin L.....4160 John R. Street, Detroit 1
Rees, Howard C.....15700 Mack Ave., Detroit 24
Reid, John G.....1553 Woodward Ave., Detroit 26
Reid, Wesley G.....3001 W. Grand Blvd., Detroit 2
Reidt, William U.....1800 Tuxedo, Detroit 6
Reiff, Morris V.....10241 Joy Rd., Detroit 4
Reinhard, Richard E.....7815 E. Jefferson Ave., Detroit 14
Reinsh, Ernest R.....18674 Muirland Ave., Detroit 21
Reisig, Robert O.....20867 Mack, Detroit 36
Reisman, Nathan J.....15344 W. McNichols Rd., Detroit 35
Reisman, Saml. G.....1553 Woodward Ave., Detroit 26
Reive, David L. E.....25447 Plymouth, Detroit 39
Remski, James E.....29447 Ravine Dr., Livonia
Reno, George L.....970 Fisher Bldg., Detroit 2
Rentenbach, Robt. F.....314 David Whitney Bldg., Detroit
Resto Soto, A. D.....17644 W. Warren, Detroit 28
Reveno, Wm. S.....3001 W. Grand Blvd., Detroit 2
Reyner, Clarence E. (L).....10 Peterboro St., Detroit 1
Reynolds, Robt. M.....856 Fisher Bldg., Detroit 2
Rezanka, Harold J.....1553 Woodward Ave., Detroit 26
Rhoades, Francis P.....2414-16 Broderick Twr., Detroit 26
Rice, Harold B.....10 Peterboro St., Detroit 1
Rice, Meshel.....533 Coats Rd., Oxford
Richardson, Allan L. (R).....Naubinway
Rick, Paul J.....12673 Joan, Detroit 5
Riddell, Wilfred A.....15420 Farmington Rd., Livonia
Ridge, Ralph W. (L).....100 Oak St., Wyandotte
Rieckhoff, Geo. G. (L).....14905 E. Jefferson Ave., Detroit 15
Rieden, James A.....18053 Muirland, Detroit 21
Rieger, John B. (L).....746 Pallister, Detroit 2
Rieger, Mary H. (L).....19285 Lucerne Dr., Highland Park
Riethmiller, Robt. F.....12444 E. Seven Mile Rd., Detroit
Rinaldo, Joseph, Jr.....Henry Ford Hosp., Detroit 2
Rinkel, Robert W.....7319 Park Ave., Allen Park
Ritter, George.....28420 Sunset Blvd., Lathrup Village
Rivera, Emiliano, Jr.....1800 Tuxedo, Detroit 6
Rizzo, Paul.....260 Eastland Prof. Bldg., Grosse Pointe
Robb, Edward L. (L).....17380 Livernois Ave., Detroit 21
Robb, Herbert J.....2706 Comfort, Birmingham
Roberts, Arthur J.....1310 Warwick Rd., Lincoln Park
Roberts, George A.....7220 Gratiot Ave., Detroit 13
Robertson, Fredk. E.....17000 W. Eight Mile Rd., Southfield
Robinson, Harold A.....10040 Yellowstone, Detroit 4
Robinson, Howard.....953 Fisher Bldg., Detroit 2
Robinson, James H., Jr.....1553 W. Grand Blvd., Detroit 8
Robinson, Remus G.....3751 31st St., Detroit 10
Rodin, Ernst A.....951 E. Lafayette, Detroit 7
Roeglin, Orville F. F.....16800 E. Warren, Detroit 24
Roehl, Karl H.....1800 Grindley Park, Dearborn
Rogers, Aaron Z.....20451 Mack Ave., Detroit 36
Rogers, Geo. E. B.....8425 Twelve Mile Rd., Warren
Rogers, John T.....29586 Five Mile Rd., Livonia
Rogers, Robert P.....18980 Wyoming, Detroit 21
Rogoff, Abraham S.....17000 W. Eight Mile Rd., Southfield
Rohde, Paul C. (L).....12282 E. Outer Dr., Detroit 24
Rom, Jack.....8600 W. McNichols Rd., Detroit 21
Roman, Stanley J.....15020 Michigan Ave., Dearborn
Romanski, Raymond.....2500 W. Grand Blvd., Detroit 8
Ronayne, John J., Jr.....16345 W. McNichols Rd., Detroit 35
Rosbolt, James F.....8505 Plymouth Rd., Detroit 4
Rosbolt, O. Paul, Jr.....8505 Plymouth Rd., Detroit 4
Rosefield, John L.....65 W. Hancock, Detroit 1
Rosen, Theodore S.....19340 Monte Vista, Detroit 21
Rosenbaum, Herbert.....18110 Muirland, Detroit 21
Rosenbaum, Jean B.....19200 Canterbury, Detroit 21
Rosenbloom, Alvin B.....17555 Parkside, Detroit 21
Rosenfeld, L. S.....1800 Tuxedo, Detroit 6
Rosenthal, Albert.....27855 Plymouth Rd., Livonia
Rosenthal, Louis H.....15401 W. McNichols, Detroit 35
Rosenthal, Saml.....8844 Joy Rd., Detroit
Rosenwach, Felix F.....19149 W. Seven Mile Rd., Detroit 19
Rosenzweig, Norman.....6767 W. Outer Dr., Detroit 35
Rosenzweig, Saul.....2542 W. Boston, Detroit 6
Ross, Charles V.....7740 Da Costa, Detroit 39
Ross, Hyman.....1016 S. Bedford St., Los Angeles, Calif.
Ross, Mervyn B.....9559 Greenfield, Detroit 27
Ross, Oscar A.....1800 Tuxedo, Detroit 6
Rotarius, Edward M.....Parke Davis Co., Detroit 32
Roth, Edward T. (L).....640 E. Grand Blvd., Detroit 7
Rother, Ina A. C.....101 Chicago Blvd., Detroit 2
Rothwell, Walter S.....2730 Chelsea, Trenton
Rottenberg, Coleman M. J.....13419 Fenkell, Detroit 27
Rottenberg, E. N.....20725 W. Seven Mile Rd., Detroit 19
Rottenberg, Leon.....13419 Fenkell Ave., Detroit 27
Roubeck, William.....17000 W. Eight Mile Rd., Southfield
Rowda, Michael S.....7 Cambridge, Pleasant Ridge
Rowe, Jos. J., Jr.....401 N. Brady, Dearborn
Roy, L. James.....1210 Kales Bldg., Detroit 26
Royer, Richard R.....18101 E. Warren Ave., Detroit 24
Rubinoff, William.....21415 W. Eight Mile Rd., Detroit 19
Ruble, Paul E.....1139 David Whitney Bldg., Detroit 26
Ruedemann, Albert D.....1553 Woodward Ave., Detroit 26
Ruedemann, Albert D., Jr.....1553 Woodward Ave., Detroit 26
Rueger, Milton J.....86 Hall Pl., Detroit 36
Rueger, Ralph C.....9149 E. Jefferson Ave., Detroit 14
Ruel, Richard E.....1515 David Whitney Bldg., Detroit 26
Ruiz, Luis C.....35084 Chestnut, Wayne
Runge, Edward F. (A).....8295 39th Ave. N, St. Petersburg, Florida
Rupe, Clarence E.....2799 W. Grand Blvd., Detroit 2
Rupp, Jacob R. (L).....247 Cass Lake Rd., Pontiac
Rupprecht, Emil F.....5525 W. Chicago Blvd., Detroit 4
Rush, Desmond K.....1429 David Whitney Bldg., Detroit 26
Ruskin, Robert L.....Sinai Hospital, Detroit 35
Ruskin, Saml. H.....1112 Kales Bldg., Detroit 26
Russanow, Georg.....400 E. Lafayette, Detroit 26
Russell, Henry N., Jr.....15101 Southfield, Allen Park
Rutzen, Arthur C.....20211 Greenfield Rd., Detroit 35
Ryan, James M.....16888 Greenfield, Detroit 35
Ryan, William D. (R).....Box 10931, St. Petersburg, Fla.
Rydzewski, Jos. B. (L).....12170 Joseph Campau, Detroit 12

Sabbagh, Enrique.....2605 W. Grand Blvd., Detroit 8
Sack, Anthony G.....18230 Grand River, Detroit 23
Sadler, Henry H., Jr.....605 Lakeland, Grosse Pointe 30
Sadzikowski, Jos. T.....1730 Hawthorne, Dearborn
Sage, Bernard A.....1013 Haigh St., Dearborn
Sage, Edward O. (L).....415 Burns Dr., Detroit 14
Sager, Edward L.....13902 Gratiot Ave., Detroit 5
St. Amour, Hector J...25515 Blossingham Dr., Dearborn Hts.
St. Louis, Rene J. (L).....10909 W. Jefferson Ave., River Rouge 18
Sakorraphos, S. N. (L).....1346 Broadway, Detroit 26
Sakwa, Saul.....17000 W. Eight Mile, Southfield
Salan, Lacy J.....995 S. Main St., Plymouth
Salchow, Paul T.....Herman Kiefer Hosp., Detroit 2
Salem, Edward S.....14520 Sherwood, Oak Park
Salhaney, Mitchell.....15252 Levan Rd., Livonia
Sall, Caroline D.....6246 Chase, Dearborn
Sallee, William T.....17000 W. 8 Mile, Southfield
Saltzstein, Harry C. (L).....850 Whitmore Rd., Detroit 3
Salvaggio, A. T.....426 Eastland Prof. Bldg., Harper Woods
Sandberg, Hershel.....19207 Schaefer, Detroit 35
Sander, Irvin W. (R).....1073 Stratford Lane, Bloomfield Hills
Sanders, Alexander W.....16350 Hamilton, Detroit 3

Sanderson, Alvord R. (L).....978 Pemberton Rd., Grosse Pointe 30
Sanderson, Susanne M. (L).....18520 West 7 Mile Rd., Detroit 19
Sandler, Nathaniel.....76 W. Adams Ave., Detroit 26
Sapala, M. Andrew.....13021 Mackenzie Ave., Detroit 28
Saraf, Leo B.....14540 E. Warren, Detroit 15
Sargent, Douglas A.....816 Grand Marais, Grosse Pointe Park
Sargent, Richard C.....17357 Fenkell St., Detroit 27
Sargent, William R.....17357 Fenkell St., Detroit 27
Sarracino, John B. (A).....34th Med. Gen. Hosp., APO 58, New York, N. Y.
Sauk, John J.....302 W. McNichols Rd., Detroit 3
Saunders, Gene A.....15121 W. 7 Mile Rd., Detroit 35
Sauter, Simon H. (L).....1082 E. Grand Blvd., Detroit 7
Savignac, Eugene M.....Holy Cross Hosp., Detroit 34
Sawdyk, Daria H.....7012 Michigan Ave., Detroit 10
Scarney, Herman D.....3011 W. Grand Blvd., Detroit 2
Schaefer, H. C.....7815 E. Jefferson, Detroit 14
Schaefer, Robt. L. (A).....76 W. Adams Ave., Detroit 26
Schaefer, Robt. L., Jr.....74 W. Adams, Detroit 26
Schaeffer, J. N.....261 Brady, Detroit 1
Schaeffer, Martin.....18275 Warrington Dr., Detroit 21
Schakne, Norman.....669 Fisher Bldg., Detroit 2
Schane, David A.....17157 Mendota, Detroit 21
Schatten, Ivan C.....2201 E. Jefferson Ave., Detroit 7
Schatz, Irwin J.....Henry Ford Hospital, Detroit 2
Scheinberg, S. R.....2240 W. Grand Blvd., Detroit 8
Schembeck, Isaac S. (L)....1553 Woodward Ave., Detroit 26
Scherer, Robert A.....470 Fisher Bldg., Detroit 2
Schidlowsky, Oleg P.....36200 Plymouth Rd., Livonia
Schiller, Arthur E. (L).....1553 Woodward Ave., Detroit 26
Schillinger, H. K.....300 Berkley, Dearborn
Schirack, Raymond D. (R).....Luzerne
Schkloven, Norman.....20051 Warrington, Detroit 21
Schlafer, Nathan H.....10 Witherell St., Detroit 26
Schlesinger, Henry.....13534 Woodward Ave., Detroit 3
Schmaltz, John D.....1701 David Whitney Bldg., Detroit 26
Schmidt, Generva F.....1074 Vernier Rd., Detroit 36
Schmidt, George J.....7106 Park Ave., Allen Park
Schmidt, Harry E.....24625 Fairmount Rd., Dearborn
Schmidt, Johann.....7815 E. Jefferson, Detroit 14
Schmidt, Klaus P.....871 Fisher Bldg., Detroit 2
Schmidt, Werner F.....1807 Stroh Bldg., Detroit 26
Schmier, Burton L. (A).....20051 Litchfield, Detroit 21
Schmitt, Norman L.....10127 W. McNichols Rd., Detroit 21
Schneck, Robt. J.....1553 Woodward Ave., Detroit 26
Schneider, Chas. L.....22148 Michigan Ave., Dearborn
Schneider, Curt P.....655 Fisher Bldg., Detroit 2
Schoenfield, Gilbert D.....8830 W. McNichols Rd., Detroit 21
Scholdager, Rolf H.....1800 Tuxedo, Detroit 6
Schooten, Sarah S.....13700 Woodward Ave., Highland Park 3
Schorer, Calvin E.....951 E. Lafayette, Detroit 7
Schroeder, Carlisle F.....26505 E. River Rd., Grosse Isle
Schroeder, Gisela.....22408 Park Lane, St. Clair Shores
Schroeder, Heinz R.....Wayne Co. Gen. Hospital, Eloise
Schuchter, S. L.....1800 Tuxedo, Detroit 6
Schulte, Carl H. (L).....28 W. Adams Ave., Detroit 26
Schultz, Clarence H.....23100 Cherry Hill, Dearborn
Schultz, Ernest C. (L).....1553 Woodward Ave., Detroit 26
Schuman, Bernard M.....Henry Ford Hospital, Detroit 2
Schwartz, Benj.....275 W. Grand Blvd., Detroit 16
Schwartz, Harold A.....7605 Puritan Ave., Detroit 38
Schwartz, Louis A. (A).....P.O. Box 315, Rockport, Mass.
Schwartz, Oscar D.....7421 W. Seven Mile Rd., Detroit 21
Schwartzberg, J. A.....19445 Plymouth, Detroit 28
Schwarz, Frank W.....23100 Cherryhill, Dearborn
Schweigert, C. F.....10627 Cadieux Rd., Detroit 24
Schwimmer, Benjamin.....8811 John C. Lodge Bldg., Detroit 2
Schwocho, Niles H.....7106 Park Ave., Allen Park
Sciarrino, Stanley V.....15388 Livernois Ave., Detroit 38
Scott, Robert J.....26075 Woodward, Huntington Woods
Scott, Wm. J. (L)....20170 Mack Ave., Grosse Pointe Woods
Screen, Raymond J.....18520 W. Seven Mile Rd., Detroit 19
Seabrooks, Benj. F., Jr.....726 Lathrop, Detroit
Secord, Eugene W. (A).....660 Whitmore Rd., Detroit 21
Segal, Andrew E.....19481 Livernois Ave., Detroit 21
Segar, Laurence F.....10 Witherell St., Detroit 26
Segel, Nathan P.....19100 Manor, Detroit 21
Seibert, Alvin H. (L).....1180 Bedford Rd., Grosse Pointe Park 30
Seiferlein, A. L.....1553 Woodward Ave., Detroit 26
Seim, Elmer J.....Grace Hospital, Detroit 1
Seitam, Karl.....10149 Michigan Ave., Dearborn
Selbst, Ronald A.....26339 Woodward, Royal Oak
Self, Wm. G.....20861 Mack Ave., Grosse Pointe 36
Sellers, Chas. W.....18545 Schoolcraft Ave., Detroit 23
Sellers, Graham A. (A).....10535 W. Seven Mile Rd., Detroit 21
Seltzer, Joseph.....20905 Greenfield, Southfield
Selzer, Isidore.....4811 John R St., Detroit 1
Senecoff, Stephen D.....16800 Greenfield, Detroit 35
Sepetys, Povilas.....25466 Clairview, Dearborn 6
Seski, Arthur G.....1069 Fisher Bldg., Detroit 2
Seto, Millard (A).....1818 Poki St., Honolulu, Hawaii
Severyn, Fred R.....15830 Fort St., Southgate
Sewell, Geo. (L).....31801 Arlington Dr., Birmingham
Sewell, Guy W.....17751 East Warren Ave., Detroit 24
Seydel, H. Gunter.....847 Westchester, Grosse Pointe Park
Shada, John C.....770 Shoreham, Grosse Pointe 36
Shafarman, Eugene M.....5320 John R St., Detroit 2
Shaffer, Jos. H.....2401 Radnor Dr., Birmingham
Shaffer, Loren W. (R).....6040 Wildrose Lane, Port Huron
Shafter, Royce R.....1188 Puritan, Birmingham
Shams Avari, Parviz.....28303 Joy Rd., Garden City
Shanoski, Stanley J.....1910 David Broderick Twr., Detroit 26
Shapiro, Jacob.....14634 E. Seven Mile Rd., Detroit 5
Shapiro, Reuben I.....910 David Broderick Twr., Detroit
Shaptini, Elias A.....1 Woodward Ave., Detroit 26
Shargel, Geo. M. J.....1800 Tuxedo, Detroit 6
Sharp, Elwood A. (A).....633 Neff Rd., Grosse Pointe 30
Sharpe, Wm. D.....24621 W. McNichols Rd., Detroit 19
Sharrer, Chas. H.....1133 Grayton, Detroit 30
Shea, Francis P.....Harper Hospital, Detroit 1
Shecter, Harry.....2200 E. Grand Blvd., Detroit
Sheehan, Irene C.....15520 Garfield, Allen Park
Sheehan, Shelia.....Det. Receiving Hosp., Detroit 26
Shekerjian, Armen.....27640 Morningside, Lathrup Village
Shelfoon, Delores J.....1660 Oakman Blvd., A 3, Detroit 38
Sherman, Marvin.....20101 James Couzens, Detroit 35
Sherman, W. LaRue (L).....10 Peterboro St., Detroit 2
Sherman, Wm. L., Jr. (A).....201 E. Kirby, Detroit 1
Sherrin, Edgar R.....19021 W. McNichols, Detroit 19
Shevin, Frederick F.....18450 Livernois, Detroit 21
Shewchuk, A. P.....7300 Allen Rd., Allen Park
Shields, Wm. L.....510 Hildale, Detroit 3
Shiffman, Milton M.....Mt. Sinai Hospital, Detroit 35
Shifrin, Peter G.....20211 Greenfield, Detroit 35
Shin, Eon.....1800 Tuxedo Ave., Detroit 6
Shiovitz, Louis.....5419 Michigan Ave., Detroit 10
Shipton, Waldo H. (A).....General Delivery, Naples, Fla.
Shlain, Benj.....19280 Berkeley, Detroit 21
Shors, Clayton M.....19635 Mack Ave., Detroit 35
Shortz, Gerald (A).....925 15th Place, Vero Beach, Fla.
Shreve, Alfred J.....4520 Firestone Ave., Dearborn
Shufro, Arthur S.....28585 Rivercrest Dr., Southfield
Shulman, Herschel A.....207 Northland Med. Bldg., Southfield
Shumaker, Edward J.....75 Lothrop, Detroit 36
Siddall, Roger S.....3011 W. Grand Blvd., Detroit 2
Sieber, Edward H.....6650 Greenfield Rd., Dearborn
Siebert, William E.....23023 Orchard Lake Rd., Farmington
Siefert, John L. (R).....P.O. Box 601, Jupiter, Fla.
Siefert, Wm. A.....17400 Grand River Ave., Detroit 27
Siegel, Henry.....19720 Chesterfield, Detroit 21
Siero, Jose M.....9105 Van Dyke, Detroit 13
Sievers, Lorraine A.....1457 David Whitney Bldg., Detroit 26
Sigler, John W.....Henry Ford Hospital, Detroit
Sill, Jacob A.....19635 Mack Ave., Detroit 36
Siller, John J.....19244 Grand River, Detroit 23
Sillery, Robt. J.....460 Lakeland, Grosse Pointe 30
Sills, Richard D.....19321 Greenfield, Detroit 35
Silvarman, Israel Z.....9105 Van Dyke Ave., Detroit 13
Silver, Donald F.....467 Fisher Bldg., Detroit 2
Silver, Israel W.....20000 W. Chicago, Detroit 28
Silver, Marvin D. (A).....Detroit Receiving Hosp., Detroit

Silver, Robert R.....20188 Wakefield, Detroit
Silverman, Maurice M.....17301 W. Eight Mile Rd., Detroit 35
Silverman, Max.....2240 W. Grand Blvd., Detroit 8
Silverstein, O. D.....17000 W. 8 Mile Rd., Southfield
Simmons, Donald R.....529 Fisher Bldg., Detroit 2
Simon, Heinz G.....12206 Morang, Detroit 24
Simpson, Gordon E.....18101 E. Warren Ave., Detroit 24
Simson, Clyde B.....951 E. Lafayette, Detroit
Singer, Floyd W.....13530 Michigan Ave., Dearborn
Sippola, Geo. W. (L).....13603 LaSalle Blvd., Detroit 38
Sisson, John M.....15901 Greenfield Ave., Detroit 27
Sivak, B. J.....24665 Santa Barbara, Southfield
Sklar, Manuel.....18400 Schaefer Rd., Detroit
Skully, Edward J.....14000 Linnhurst, Detroit 5
Sladen, Frank J. (L).....Henry Ford Hospital, Detroit 2
Slahetka, Vincent E.....19334 Bretton Dr., Detroit 23
Slaugenhaupt, J. G. (L).....16887 Lawton, Detroit 21
Slaughter, Fred M. (L).....2562 Ferry Park, Detroit 8
Slazinski, Leo W. (L).....7618 Michigan Ave., Detroit 10
Slevin, John G.....1132 Whittier Ave., Grosse Pointe Park
Sliwin, Edward P.....13244 W. Warren, Dearborn
Slusky, Jos.....854 Fisher Bldg., Detroit 2
Sly, Robt. F.....2101 Monroe Blvd., Dearborn 8
Small, Henry.....15300 W. McNichols Rd., Detroit
Small, John.....2643 E. Seven Mile, Detroit 34
Smathers, Homer M.....14219 W. McNichols, Detroit 35
Smathers, Ward M.....14219 W. McNichols, Detroit 35
Smeck, Arthur R. (L).....1036 Waterman Ave., Detroit 9
Smiggen, James J.....19647 Joy Road, Detroit 28
Smith, Andrew J.....2950 Puritan, Detroit 38
Smith, Claude A. (L).....7 Adams Lane, Dearborn
Smith, Douglas H.....10151 Michigan, Dearborn 2
Smith, F. Janney (L).....352 Moselle Pl., Grosse Pointe Farms
Smith, Henry L.....16401 Grand River Ave., Detroit 27
Smith, J. Allen.....14140 Puritan Ave., Detroit 27
Smith, Richmond W., Jr.....2799 W. Grand Blvd., Detroit 2
Smith, Roger F.....18755 Wilshire Ave., Lathrup Village
Smith, W. Pierce.....Henry Ford Hospital, Detroit 2
Smolenski, John J.....13815 Puritan Ave., Detroit 27
Smyka, Stanley M.....15731 Glenwood, Detroit 5
Snider, Eugene A.....20905 Greenfield, Southfield
Snider, Thomas H.....V.A. Hospital, Dearborn
Snoke, Edwin C.....2901 West Rd., Trenton
Snow, Linwood W.....508 W. Main St., Northville
Snyder, Richard J.....32817 Barkley, Livonia
Sobel, Robt. A.....18980 Wyoming, Detroit 21
Soble, Allen R.....18241 Greenfield, Detroit 35
Soderberg, Ralph B.....7815 E. Jefferson Ave., Detroit 14
Soifer, Sidney.....Sinai Hospital, Detroit 35
Sokol, Wm. M.....15800 W. McNichols, Detroit 35
Sokolov, Raymond A.....3011 W. Grand Blvd., Detroit 2
Sokolowski, A. H.....5550 Mitchell Ave., Detroit 11
Solberg, Lincoln E.....2021 Monroe, Dearborn
Soller, Alex S.....19309 Greenfield, Detroit 35
Solomon, A. B.....9559 Greenfield, Detroit 27
Solomon, Robert J.....15101 Southfield, Allen Park
Somerville, Thos. H.....36475 Five Mile Rd., Livonia
Sonda, Lewis P. (R).....1553 Woodward Ave., Detroit 26
Sonda, Lewis P., Jr.....5132 Allen Rd., Allen Park
Sorock, Milton L.....19467 Livernois, Detroit 21
Sosa, Carlos M. A.....10824 Talbot St., Huntington Woods
Speck, Carlos C.....6742 Park Ave., Allen Park
Spector, Maurice J.....12938 E. Jefferson, Detroit 15
Sperry, Frederick L. (A).....490 Arlington, Berkeley, Calif.
Sphire, Raymond D.....4160 John R St., Detroit 1
Spiegelmann, H. L.....15361 Plymouth, Detroit 27
Spiro, Adolph S.....13240 Harper, Detroit 13
Spiwak, Bertram J.....7407 Cathedral Dr., Birmingham
Springborn, Benj. R. (L).....15818 E. Warren Ave., Detroit 24
Sprunk, Carl J.....2900 Oakwood Blvd., Melvindale
Squires, Walter M. (R).....1616 S. 28 Ave., St. Petersburg, Fla.
Stalker, Hugh (R)....Cottage Hospital, Grosse Pointe Farms
Stamell, Benjamin B.....17000 W. Eight Mile Rd., Southfield
Stamell, Meyer.....14634 Greenfield St., Detroit 27
Stanton, James M.....1001 Mutual Bldg., Detroit 26
Stanton, Myron R.....3400 W. Warren, Detroit 8
Stapleton, Wm. J., Jr. (L).....201 E. Kirby Ave., Detroit 2
Staricco, Renato.....3725 Fort St., Lincoln Park
Staryk, Steven E.....1010 N. Oxford Rd., Detroit 36
Statzer, Darrell E.....955 Fisher Bldg., Detroit 2
Staub, Howard P.....37625 Michigan Ave., Wayne
Staudt, Louis W.....1201 Pilgrim, Birmingham
Stearns, Alexander B.....7430 Second, Detroit 2
Stebbins, Chas E.....705 Northland Med. Bldg., Southfield
Steepe, Chas. A. D.....20867 Mack, Grosse Pointe Woods
Stefani, Andrew E.....1701 N. Renaud, Detroit 36
Stefani, Ernest L.....18455 Jas. Couzens Hwy., Detroit 35
Stefani, Raymond T.....13526 Stoepel, Detroit 38
Stein, Albert H.....19334 San Juan Dr., Detroit 21
Stein, Emory.....13115 Woodward, Detroit 3
Stein, Harvey S.....19075 Middlebelt Rd., Livonia
Stein, Saul C.....23105 Van Dyke, Van Dyke
Steinbach, A. L.....320 Merriweather Rd., Grosse Pointe 36
Steinberger, E. J. (L).....6402 W. Fort, Detroit 9
Steiner, Fredk. B.....7675 Ridge Rd., Plymouth
Steiner, Gabriel (L).....10 Peterboro St., Detroit 1
Steiner, S. D.....3044 W. Grand Blvd., Detroit 2
Steinhardt, Milton J.....10720 W. Seven Mile Rd., Detroit 21
Stellhorn, Chester E.....12900 W. Seven Mile Rd., Detroit 35
Stellhorn, Mary C. (A).....16616 Mack Ave., Detroit 24
Stempel, Edward M.....18324 Fairfield Ave., Detroit 21
Sterba, Richard F.....1130 Parker Ave., Detroit 14
Stern, Edward A.....12710 Dexter Blvd., Detroit 38
Stern, Joseph W.....15101 W. Seven Mile, Detroit 35
Stern, Julian.....15121 W. McNichols Rd., Detroit 35
Stern, Leonard H.....19200 Aften Rd., Detroit 3
Stern, Louis D. (L).....1553 Woodward Ave., Detroit 26
Stern, Sheldon D.....802 Mutual Bldg., Detroit 26
Sternhill, Vernon.....1800 Tuxedo, Detroit 6
Stevens, Chas. H.....Med. Concourse NC, Southfield
Stevenson, Chas. S.....411 Professional Bldg., Detroit
Stevenson, Lee B.....Henry Ford Hosp., Detroit 2
Stewart, Lula B.....8633 Dexter Blvd., Detroit 6
Stewart, Maitland N., Jr.....20905 Greenfield, Southfield
Stewart, Robert M.....15357 Farmington Rd., Livonia
Stewart, Marjorie (A).....581 Golfcrest, Dearborn
Stiefel, Danl. M.....1553 Woodward Ave., Detroit 26
Stillwater, Karl.....18221 Pennington, Detroit 21
Stith, Dwight E.....505 Owen St., Detroit 2
Stobbe, Godfrey D.....Grace Hospital, Detroit 1
Stock, Thomas B.....19610 Middlesex, Southfield
Stocker, Lawrence L.....7310 W. 7 Mile Rd., Detroit
Stocker, Marvin L.....16401 Grand River, Detroit
Stockwell, Benj. W.....3919 John R St., Detroit 1
Stokfisz, Thaddeus.....7012 Michigan, Detroit 10
Stoller, Raymond.....25210 Grand River Ave., Detroit 40
Stone, Sidney L.....14620 E. Seven Mile Rd., Detroit 5
Stoyka, Michael R.....8487 Kenny, Detroit 34
Straith, Richard E.....2605 W. Grand Blvd., Detroit 8
Strand, Martin E.....22400 Cherry Hill, W. Dearborn
Strauss, Ernest G.....1326 St. Antoine, Detroit 26
Stricker, Henry D.....5624 W. Fort St., Detroit 9
Strickler, D. T., Jr.....22231 W. Outer Dr., Dearborn
Strickroot, Fred L.....3800 Bishop Rd., Detroit 24
Stronski, G. E.....9901 Whittier, Detroit 24
Stryker, Joan C.....21604 E. River Rd., Grosse Ile
Stryker, Walter A.....P.O. Box 31, Wyandotte
Stubbs, Clayton T. (R).....126 S. Gratiot, Mt. Clemens
Stubbs, Harold W. (L).....13930 Woodward Ave., Detroit 3
Subrin, Mayer.....18048 Woodingham, Detroit 21
Suen, Irene T. S.....3675 E. Outer Dr., Detroit 34
Sugar, David I. (L).....18104 Oak Dr., Detroit 21
Sugar, H. Saul.....18140 San Juan Dr., Detroit 21
Sugarman, Marcus H.....15201 W. McNichols, Detroit 35
Sugayan, Norberto A.....Wayne Co. Gen. Hosp., Eloise
Sullivan, Hugh A. (L).....1553 Woodward Ave., Detroit 26
Sullivan, Thomas M.....951 E. Lafayette, Detroit 7
Sullivan, Paul J.....761 Fisher Bldg., Detroit 2
Sultzman, L. Carl.....55 Vendome, Grosse Pointe Farms 36
Summers, Wm. A.....1553 Woodward Ave., Detroit 26
Summers, Wm. S. (L)....402 N. Palmway, Lake Worth, Fla.
Sutherland, Jacob M. (L).....716 Pallister, Detroit
Suwinski, Raymond H.....9801 Conant St., Hamtramck 12
Swan, Donald C.....17000 W. Eight Mile Rd., Southfield
Swanson, Carl W.....936 Alter Rd., Detroit 15
Swanson, Robt. G.....17800 E. 8 Mile Rd., Detroit 36

Swartz, Fred G., Jr.....1329 David Whitney Bldg., Detroit 26
Sweeny, Donald N., Jr.....8445 E. Jefferson, Detroit 14
Switzer, Bertrand C. (R).....1862 Riverside, Columbus 21, Ohio
Syphax, Charles S.....1819 E. Davison, Detroit 3
Szabunia, Sigmund C.....19600 Van Dyke, Detroit 34
Szappanyos, G. G.....Providence Hosp., Detroit 8
Szilagvi, D. Emerick.....Henry Ford Hospital, Detroit 2
Szladek, Frank J.....4045 W. Jefferson Ave., Ecorse 29
Szmigiel, Alex J.....20060 Kelly, East Detroit
Taber, Rodman E.....Henry Ford Hosp., Detroit 2
Tactac, Albert J.....15244 Middlebelt, Livonia
Talbot, Frank G.....1365 Cass, Detroit 26
Tallant, Edward J.....18041 Greenfield, Detroit 35
Talley, Robt. W.....Henry Ford Hosp., Detroit 2
Talmers, Fredk. N.....V.A. Hospital, Dearborn
Tamblyn, E. J. (L).....737 Marlborough, Detroit 15
Tanay, Emanuel.....861 Fisher Bldg., Detroit 2
Tapert, Julius C.....888 Chalmers Ave., Detroit 15
Tarpinian, Harry.....10955 Farmington Rd., Livonia
Tasker, Helen E.....76 W. Adams Ave., Detroit 26
Tassie, Ralph N. (L).....15000 Gratiot Ave., Detroit 5
Tatelis, Gabriel A.....1011 E. Grand Blvd., Detroit 7
Tatelman, Maurice.....1420 St. Antoine, Detroit 26
Taurence, Wm. H.....1860 Ford Ave., Wyandotte
Taylor, Ivan B.....30 N. Edgewood Dr., Grosse Pointe Shores
Taylor, Junius L.....2433 W. Boston Blvd., Detroit 6
Taylor, Nelson M.....215 Dean Lane, Grosse Pointe Park 36
Taylor, Richard A.....28 W. Adams St., Detroit 26
Taylor, Ward M.....2201 E. Jefferson Ave., Detroit 7
Taylor, Wm. V.....17200 E. Warren, Detroit 24
Tazzioli, Henry A.....21970 Moross Rd., Detroit 36
Tear, Malcolm J. J.....862 W. McNichols Rd., Detroit 3
Teitelbaum, Myer.....18510 Meyers Rd., Detroit 35
Tenaglia, Thos. A.....3180 Fort St., Lincoln Park
Teves, Manuel L.....13020 Mack, Detroit 15
Texter, Elmer C. (L).....7457 Gratiot Ave., Detroit 13
Thal, Alan P.....687 Balfour, Detroit 36
Thomas, Alfred E.....73 E. Palmer, Detroit 2
Thomas, Blanche M.....6535 Allen Rd., Allen Park
Thomas, Leon D.....3019 West Warren, Detroit 8
Thomas, L. Murray....801 David Whitney Bldg., Detroit 26
Thompson, Arthur L.....12632 Dexter, Detroit 38
Thompson, Hugh O.....6014 W. Fort St., Detroit 9
Thompson, Wm. A. (R).....12632 Dexter, Detroit 38
Thomson, Danl. C.....2934 Biddle Ave., Wyandotte
Thornell, Harold E.....2536 W. Grand Blvd., Detroit 8
Thosteson, G. C.....1139 David Whitney Bldg., Detroit 26
Thumann, Robt. C...20045 Mack Ave., Grosse Pointe Woods
Thumim, Sadie.....15306 Joy Rd., Detroit 28
Timma, Richard J.....16401 Grand River Ave., Detroit 27
Ting, Yoeh Ming.....16024 Stratford Dr., Southfield
Tkaczuk, Dmytro.....10345 Joseph Campau, Detroit 12
Toal, Robert E.....20953 Grand River, Detroit 19
Todoroff, Theodore G.....22146 Ford Rd., Dearborn 6
Tolbert, Vassal G.....3461 W. C. Chrysler Exp., Detroit 1
Tomsu, Chas. L. (L)....16521 Westmoreland Rd., Detroit 19
Torp, Raymond T.....722 Notre Dame, Grosse Pointe 30
Torres, Estelle P.....3985 Caniff, Hamtramck 12
Torres, Raul M., Jr.....3985 Caniff St., Hamtramck 12
Tourkow, Lawrence P.....3290 Sherbourne Rd., Detroit 21
Tourney, Garfield.....Lafayette Clinic, Detroit 7
Townsend, Frank M., Jr.....1055 Trumbull, Detroit 16
Tracey, John M.....15317 W. McNichols, Detroit 35
Tracy, Edward G.....3411 Evaline St., Detroit 12
Trader, Kenneth N.....3001 W. Grand Blvd., Detroit 2
Treisman, E. J.....15105 W. Seven Mile Rd., Detroit
Tremain, Harold L.....15475 Ashton, Detroit 23
Triska, Franz K.....12444 E. Seven Mile Rd., Detroit 5
Troester, Geo. A.....81 E. Kirby, Detroit 2
Trombino, James F. V.....8625 Marygrove Dr., Detroit 21
Trotsky, Martin B.....7411 Third Ave., Detroit 2
Truba, Paul K.....22770 Kelly Rd., East Detroit
Trudeau, John M.....14200 Puritan, Detroit 21
Trudgen, Paul E.....1224 Beechmont, Dearborn
Trunsky, Ronald E.....Sinai Hospital, Detroit 35
Trupiano, Samuel.....420 Eastland Prof. Bdg., Detroit 36
Trythall, S. W.....Box 33, Orchard Lake
Tseng, George T. C.....Annapolis Hosp., Wayne
Tulloch, John A.....1807 Dav. Whitney Bldg., Detroit 26
Tulloch, John C.....1040 Dav. Whitney Bldg., Detroit 26
Tupper, Roy D. (L).....15101 W. 7 Mile Rd., Detroit 19
Turcotte, Vincent J. (A).....545 Lakeland, Grosse Pointe
Turkel, Henry.....8000 W. Seven Mile Rd., Detroit 21
Turner, Edward T.....5050 Joy Rd., Detroit 4
Turner, Rachel E.....3113 Evergreen, Royal Oak
Turner, Robert R.....2841 Monroe Blvd., Dearborn
Uddyback, Odie T.....8401 Woodward Ave., Detroit 2
Ujda, Chester J.....32126 Woodbrook, Wayne
Ulmer, Arthur A.....1989 Broadstone, Detroit 36
Ulrich, Elmer E.....5596 Eastlawn, Detroit 13
Ulrich, Willis H.....22365 Grand River Ave., Detroit 19
Umphrey, Clarence E. (L).....6216 Hill Dr., Birmingham
Unkefer, Wm. T.....15800 W. McNichols Rd., Detroit 35
Usndek, Harold E.....18485 Mack Ave., Detroit 36
Vaitas, Otonas.....10531 Farmington Rd., Livonia
Vaitkevicius, V.....4811 John R St., Detroit 1
Vale, Clair F. (R).....2615 Via Tuscany, Winter Pk., Fla.
Van Arsdale, Wm. L. (A).....APO 301 S Da Mission, San Francisco, Calif.
Van Becelaere, L. A.....15830 Fort, Southgate
Vanden Berg, H. J., Jr.....1553 Woodward Ave., Detroit 26
Vander, Seymour A.....22341 W. 8 Mile Rd., Detroit
Van Eck, James E.....1716 E. Grand Blvd., Detroit 11
Van Hoek, Donald E.....20323 Mack, Grosse Pte. Wds.
Van Raaphorst, L. F.....861 Monroe, Dearborn
Van Slyck, E. J.....Henry Ford Hosp., Detroit 2
VanValzah, Henry J.....Ford Mtr. Co., Miller Rd., Dearborn
Vardon, Edward M.....12897 Woodward Ave., Highland Park 3
Vasu, Vasile O.....4829 Woodward Ave., Detroit 1
Veling, William F.....3001 W. Grand Blvd., Detroit 2
Vera, Ramon W.....106 W. Davison, Highland Park 3
Vincent, Charles C.....2424 Puritan, Detroit 38
Vincent, John W.....22214 Ford Rd., Dearborn
Vipond, W. Fraser.....15398 Gratiot Ave., Detroit 5
Viscomi, Geo. J.....23422 Ford Rd., Dearborn
Visscher, Donald W.....12922 W. Warren, Dearborn
Vokes, Milton D. (L).....10182 Gratiot Ave., Detroit 13
Vonberg, Vollrad J.....14540 Warren, Detroit 24
Vonder Heide, Elmore C.....17190 Strathmoor, Detroit 35
Vorwald, Arthur J.....1401 Rivard St., Detroit 7
Vossler, Albert E.....1553 Woodward Ave., Detroit 26
Waehneldt, Niels R.....Henry Ford Hosp., Detroit 2
Wagenberg, Harold R.....19947 Lahser Road, Detroit 19
Waggoner, Lyle G.....404 Dav. Whitney Bldg., Detroit 26
Wahl, Richard A.....17555 Jas. Couzens Hwy., Detroit 35
Wainger, Max J.....15105 W. 7 Mile Rd., Detroit 35
Wainstock, Michael A.....621 David Whitney Bldg., Detroit 26
Wakeman, Everal M.....23100 Cherry Hill, Dearborn
Waldbott, Geo. L.....2930 W. Grand Blvd., Detroit 2
Walker, Frank B., II.....1305 Berkshire Rd., Grosse Pte.
Walker, Geo. L.....7815 E. Jefferson Ave., Detroit 14
Walkowiak, Robt. G.....76 W. Adams Ave., Detroit 26
Wallace, Silas W. (L).....7815 E. Jefferson Ave., Detroit 14
Wallaert, Albert A. J.....415 Burns, Detroit
Waller, John P.....25447 Plymouth, Detroit 39
Walser, Howard C.....459 Fisher Bldg., Detroit 2
Walsh, Francis P.....654 Fisher Bldg., Detroit 2
Walt, Alexander J.....Detroit Receiving Hosp., Detroit 26
Walter, Arthur W.....14201 Rutland Rd., Detroit 27
Walter, Floyd J.....18714 Grand River Ave., Detroit 23
Wang, Chun Heng H.....25500 Edgemont, Southfield
Wang, Joy Ya Hsiang.....35550 Michigan, Wayne
Warner, Peter L. (L).....15320 Artesian Ave., Detroit 23
Warren, Bernice K.....18984 Livernois, Detroit 21
Warren, Irving A.....18984 Livernois, Detroit 21
Warren, Max W.....20001 Shrewsbury St., Detroit 21
Warren, Wadsworth (A).....415 Burns Dr., Detroit 14
Wasserman, Harold....19001 W. Seven Mile Rd., Detroit 19
Wasserman, Lewis C.....300 W. McNichols Road, Highland Park 3
Waszak, Chas. J.....2501 W. Grand Blvd., Detroit 8
Waters, Williams L.....19203 Grand River, Detroit 23
Watson, Harwood G.....935 S. Military Ave., Dearborn
Watson, James E., Jr.....18524 Grand River, Detroit 23
Watts, Fredk. B.....16321 Mack Ave., Detroit 24
Watts, John C.....7360 12th St., Detroit
Watts, Jos. C.....20905 Greenfield, Southfield
Wayne, Morris A.....15930 Livernois Ave., Detroit 38

Weaver, Clarence E. (R).....1260 S.E. Fourth Ct., Deerfield Beach, Fla.
Weaver, Delmar F.....1100 Bishop, Detroit 30
Weber, Karl W.....18101 E. Warren Ave., Detroit 24
Webster, Jeremy D.....20045 Mack, Grosse Pointe
Webster, John E. (A).....47 Pine Court, Detroit 26
Weckstein, Marvin S.....18627 Tracey, Detroit 35
Weed, Milton R.....1059 Berkshire Rd., Grosse Pte. Pk. 30
Wehenkel, Albert M. (L).....7356 12th St., Detroit 6
Wehr, Maurice B.....2355 Fort St., Lincoln Park
Weiksnar, John F.....1800 Tuxedo, Detroit 6
Weiner, Allen D.....21415 W. Eight Mile, Detroit 19
Weiner, Maurice B.....20211 Greenfield, Detroit 35
Weingarden, David (L).....13240 Vassar Dr., Detroit 35
Weinstein, Jacob.....4237 Grand River Ave., Detroit 8
Weintraub, G. S.....13735 W. 8 Mile Rd., Detroit
Weisberg, A. Allen.....20 W. Seven Mile Rd., Detroit 3
Weisberg, Harry.....15101 W. McNichols Rd., Detroit 35
Weisberg, Jacob.....15101 W. McNichols Rd., Detroit 35
Weisenthal, Irvin I.....5764 Woodward Ave., Detroit 2
Weiss, Casimir P.....1801 E. Canfield, Detroit 7
Weiss, Morris.....Hawthorn Center, Northville
Weissman, Fredrick.....20905 Greenfield Rd., Southfield
Welch, John H.....18550 W. Outer Dr., Dearborn 7
Weller, Chas. N. (R).....730 Watervale Rd., Arcadia
Wells, Herschel J.....Wayne Co. Gen. Hosp., Eloise
Wells, Martha L.....760 Fisher Bldg., Detroit 2
Weltman, Carl G. (A).....Rt. 2, Snead Island, Palmetto, Fla.
Wendt, Vernon E.....Detroit Rec. Hosp., Detroit 26
Wenokur, Milford E.....15845 New Hampshire, Southfield
Wenzel, Jacob F.....18555 E. Warren, Detroit 36
Werle, Peter P.....1420 St. Antoine, Detroit 26
Wertz, Wm. J.....Det. Receiving Hosp., Detroit 26
West, George A. (A).....6303 Mack Ave., Detroit 7
West, Malcolm E.....6309 Charlevoix, Detroit 7
Weston, Bernard.....20403 Snowden Ct., Detroit 35
Weston, Earl E.....18101 Jas. Couzens Hwy., Detroit 35
Weston, Horace L.....28 W. Adams St., Detroit 26
Weyher, Russell F.....5383 Oakman Blvd., Detroit 4
Whalen, Neil J.....1553 Woodward Ave., Detroit 26
Whaley, Robert L.....20901 Moross Rd., Detroit 36
Wharton, Thos. V.....1809 Oak St., Wyandotte
Wheatley, Charles E.....4407 Roemer, Dearborn
Wheeler, Stewart C.....18901 W. McNichols Rd., Detroit 19
Whelan, Jos. L.....1360 Oxford Rd., Detroit 36
White, Donald H.....20685 Meridian, Grosse Ile.
White, Jacob E.....3413 McDougall, Detroit 7
White, Milton W.....1439 E. Outer Dr., Detroit 34
White, Prosper D.....58 W. Adams Ave., Detroit 26
White, Theodore M.....7159 Michigan, Detroit 10
Whitehead, Leston S.....1553 Woodward Ave., Detroit 26
Whitehead, Walter K.....1553 Woodward Ave., Detroit 26
Whitehouse, Fred. W.....2799 W. Grand Blvd., Detroit 2
Whiteley, Robt. K.....608 Eastland Cen. Prof. Bldg., Detroit 36
Whitelock, Edward H.....1809 Oak St., Wyandotte
Whitman, James E.....3137 E. Seven Mile Rd., Detroit 34
Whitney, Elmer L. (L)....2 Kenberton Rd., Pleasant Ridge
Whitrock, Robt. M.....20250 Mack Ave., Grosse Pointe 36
Whittaker, Alfred H. (L).....17000 E. Jefferson Ave., Grosse Pte. 30
Whitten, James I.....18948 Appoline, Detroit 35
Wiechowski, Henry E.....10345 Joseph Campau, Detroit 12
Wiener, Israel.....13011 W. McNichols Rd., Detroit 35
Wiener, Morton J.....150 Livernois, Ferndale 20
Wietersen, Fred. K.....18700 Meyers Rd., Detroit 35
Wikiera, Edward S.....15120 Michigan, Dearborn
Wilcox, Leslie F. (A).....505 Middlesex Rd., Grosse Pt. Park
Wilhelm, Rudolf E.....751 S. Military Rd., Dearborn 7
Wilhelm, Seymour K.....13011 W. McNichols, Detroit 35
Wilkinson, Arthur P. (R).....4840 Willow Lane, Orchard Lake
Willard, Rodney E. (A).....893 Nottingham Dr., Avondale Estates, Ga.
Williams, Clarence J.....1342 Grayton Rd., Grosse Pte. 30
Williams, Delford G.....5050 Joy Road, Detroit 4
Williams, Earl R.....4407 Roemer, Dearborn
Williams, Eugene W.....15326 Michigan, Dearborn
Williams, John H.....18633 Mack Ave., Detroit 36
Williamson, W. A.....2585 W. Grand Blvd., Detroit 8
Willis, Robt. L., Jr.....Harper Hospital, Detroit
Willoughby, Wm. A.....974 Fisher Bldg., Detroit 2
Wilner, Freeman M.....15001 W. Eight Mile Rd., Detroit 35
Wilner, Irvin A.....17701 McNichols Rd., Detroit 35
Wilson, Andrew G.....19203 Grand River Ave., Detroit 23
Wilson, Francis M.....15439 Harper, Detroit 24
Wilson, Gerald A. (L).....771 Fisher Bldg., Detroit 2
Wilson, Gerald S.....3011 W. Grand Blvd., Detroit 2
Wilson, Ian D.....19203 Grand River, Detroit 23
Wilson, Merton C.....15439 Harper Ave., Detroit 24
Winnick, Lawrence C.....13340 W. Seven Mile, Detroit 35
Winton, Geo. J.....1150 Griswold St., Detroit 26
Wise, Robt. K.....17640 W. 12 Mile Rd., Southfield
Wishropp, Edward A.....20250 Mack, Grosse Pte. 36
Withey, Grant J.....7430 Second, Detroit 2
Wittenberg, Arthur A.....7101 W. Chicago Blvd., Detroit 4
Wittenberg, Samson S.....18718 Woodward, Detroit 3
Wittenberg, Sydney S.....4400 Livernois Ave., Detroit 10
Witter, Jos. A.....344 Glendale Ave., Highland Park 3
Witus, Morris (A).....1500 Bay Rd., Miami Beach, Fla.
Wlodarczyk, A. J.....4401 Conner, Detroit 15
Wolfe, John N.....432 E. Hancock, Detroit 1
Wolfe, Max O.....7-260 Gen. Mtrs. Bldg., Detroit 2
Wolfson, Wm. Q.....3000 Seminole, Detroit 14
Wollank, Helen W.....15439 Harper, Detroit 24
Wolodzko, Joseph.....32900 Five Mile Rd., Livonia
Wolter, James G.....Mt. Carmel Mercy Hosp., Detroit 35
Womack, Melisande.....1800 Tuxedo, Detroit 6
Wood, Alfred L.....23100 Cherry Hill, Dearborn
Wood, Douglas J.....2860 Clark Ave., Detroit 10
Wood, Kenneth A.....3919 John R St., Detroit 1
Wood, Wilford C.....3011 W. Grand Blvd., Detroit 2
Woodbury, Ralph F.....15850 E. Warren, Detroit 24
Woodley, Bernard J.....3700 West Rd., Trenton
Woods, Joseph J.....18255 W. McNichols, Detroit
Woolfenden, Jos. B.....1215 Three Mile Dr., Grosse Pte. Park
Worrell, Calier H.....20250 Mack, Grosse Pte. Woods
Worzniak, Jos. J.....2312 Biddle Ave., Wyandotte
Wreggit, Winston R.....17 Colorado Ave., Highland Park 3
Wright, Charles H.....50 Westminster, Detroit 2
Wruble, Jos.....411 Selden Ave., Detroit 1
Wyatt, Rudolph A.....2785 S. Fort St., Detroit 17
Wybranowski, Jan.....17644 W. Warren, Detroit 28
Wyche, Norvil.....525 Visger Rd., Ecorse
Wylie, John H.....Henry Ford Hosp., Detroit 2
Yarjanian, Ara.....3815 Pelham Rd., Dearborn
Yarrows, Morton I.....455 Medbury St., Detroit 2
Yates, Arthur J. W.....16355 E. Jefferson, Grosse Pointe Pk.
Yesayian, H. G. (L).....609 Kales Bldg., Detroit 26
Yetzer, Wm. J.....20233 Ann Arbor Tr., Dearborn
Yoder, Robt. R.....20189 Whipple, Northville
Yott, Wm. J.....854 Lakeshore Rd., Detroit 36
Young, David J.....19820 Plymouth Rd., Detroit 28
Young, Donald A.....14807 W. McNichols Rd., Detroit 35
Young, Donald C. (R).....43875 Nine Mile Rd., Northville
Young, Irving I.....32280 Shrewsbury, Farmington
Young, M. O.....8445 E. Jefferson, Detroit 14
Young, Richard D.....18000 James Couzens Hwy., Detroit 35
Young, Viola M. (L).....10 Peterboro St., Detroit 1
Young, Watson A.....43691 Expressway, Belleville
Youngstrom, Clarence S.....8004 Lochdale, Dearborn
Zabinski, Edward J.....585 Ballantyne Rd., Detroit 36
Zadeh, A. T.....27489 W. Six Mile Rd., Livonia
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Zavell, Paul M.....1932 Broadstone, Grosse Pte. Woods
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Ziegler, Robt. F.....Henry Ford Hospital, Detroit 2

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Zirkin, Richard M.....Sinai Hospital, Detroit 35
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Zubroff, L. S.....752 Fisher Bldg., Detroit 2
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Zukowski, Sigmund A.....6626 Van Dyke Ave., Detroit 13
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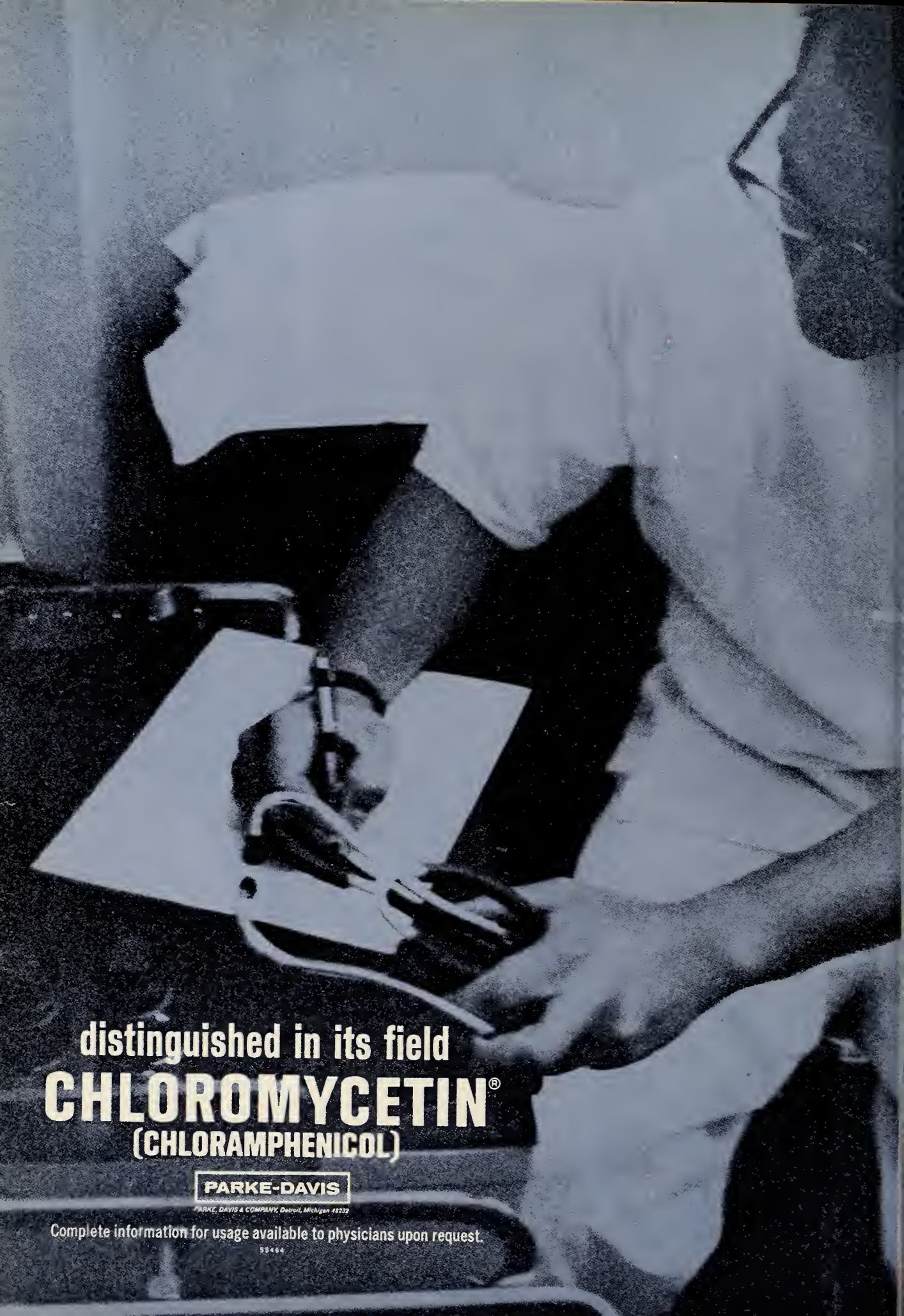
the journal of the michigan state medical society

November 1964 • Vol. 63 • No. 11

In this issue of Michigan Medicine, you'll find More Photographs from the 1964 MSMS Annual Session □ An abstract of the September Meeting of The MSMS Council □ A well-illustrated Original Article about Cervical Spine and Spinal Cord Injuries □ New Statistics about MAA Payments in Michigan □ Many Reports about Activities of Ancillary Groups □ Comprehensive Guest Editorial about Some Factors Influencing the Therapeutic Value of a Medicinal Agent □ Another Article in the MSMS Centennial Series □

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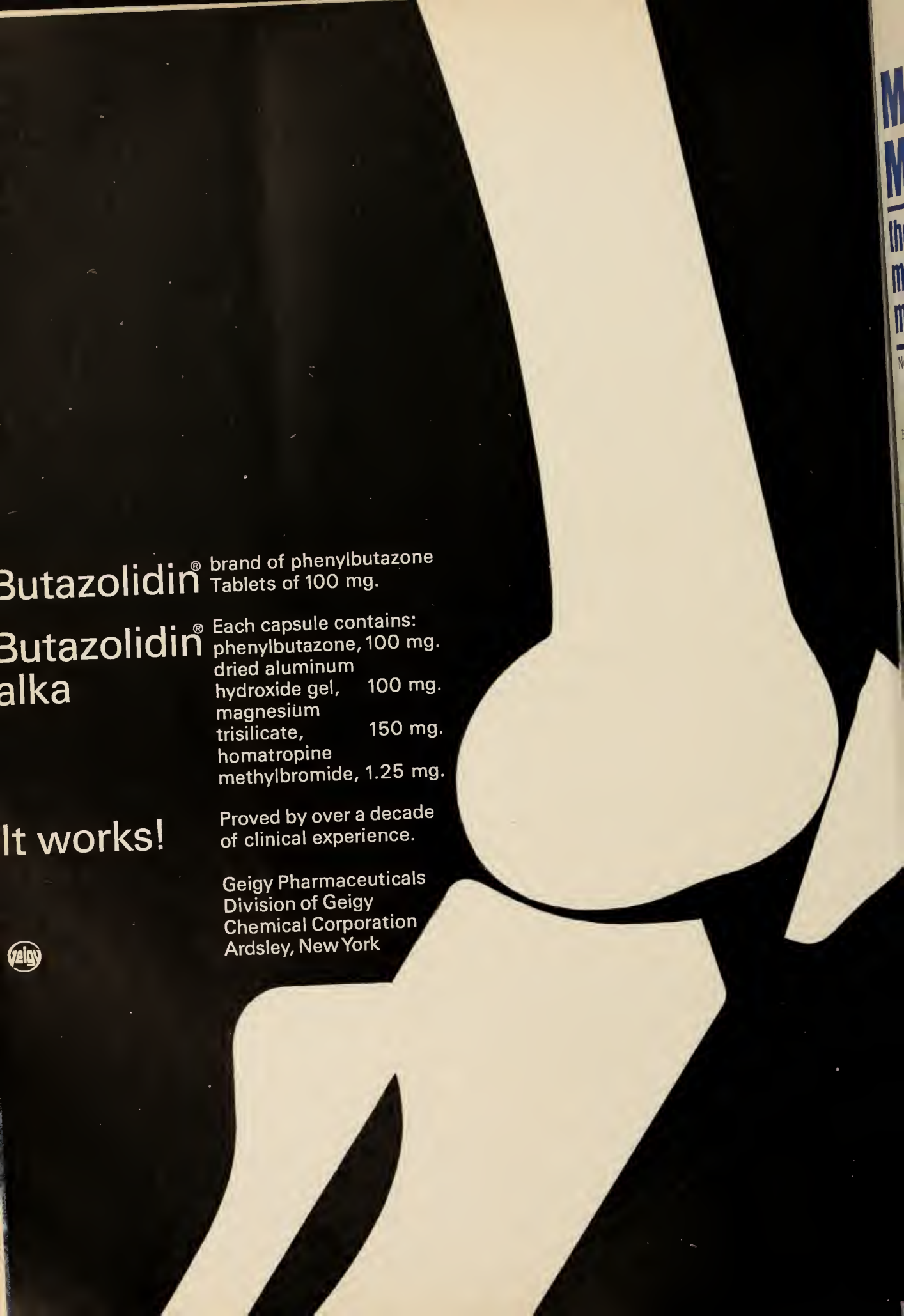
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1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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Cover photo: MSMS Council Chairman Harold H. Hiscock, M.D., installs Oliver B. McGillicuddy, M.D. (left) as the new MSMS President at the recent annual session.

President's Message

Our Obligation to Tomorrow

By OLIVER B. McGILLICUDDY, M.D.
MSMS President

What sort of young men and women are we training for medical careers?

The members of the Michigan State Medical Society who teach in our medical schools are authorities on the subject. Those of us who only encounter a medical student occasionally or meet them after they become interns if we are fortunate enough to have a resident staff, are pleased with what we see. Delegates attending the recent House of Delegates meeting must have been impressed with the leaders of their classes and the officers of the Student AMA from our two schools who were guests.



I am privileged to quote three paragraphs from a recent letter to me from William C. Munn, II, President of the WSU Senior Class.

"I would like to thank you and the Michigan State Medical Society personally, first of all, for the wonderful opportunity afforded to me as a Student Delegate to the annual convention this year.

"Your hospitality was warm, full, and greatly appreciated. I experienced, learned, and saw so very much that I must admit that I was a bit overwhelmed by it all.

"I was especially impressed and delighted with the sessions of the House of Delegates. I am not sure what I expected as I entered that first session on Sunday evening, but I assure you that by the final session on Tuesday evening I was thoroughly aware of the sagacity, democracy, and truly foresighted resolutions of the society. I was especially impressed by the deep concern that each and every delegate expressed over the quality and kind of medical care provided for the people of this democratic state and nation. The cautious and yet definite progress that this society demands of itself and its members is worthy of sincere praise in any circle, especially within the profession itself."

Our obligation is to be sure that these embryo doctors will have an opportunity to apply their idealism and knowledge in an atmosphere of medical freedom such as we have enjoyed. And, to see that they are not hampered by the stifling oppression of bureaucratic control.

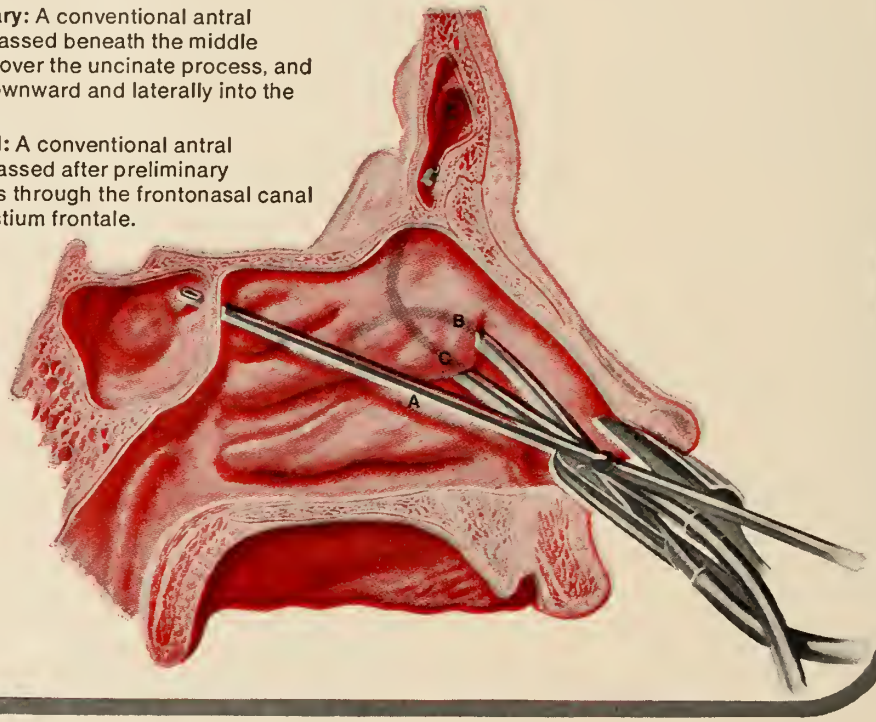
Annual Session Photos — Pages 807, 808, and 811

A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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Members are invited to submit to the Journal any suggestions for the welfare of the Society, as well as comments or criticisms of any material in the Journal. All such communications should be directed to the Publication Committee of the Journal. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted to it.

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11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

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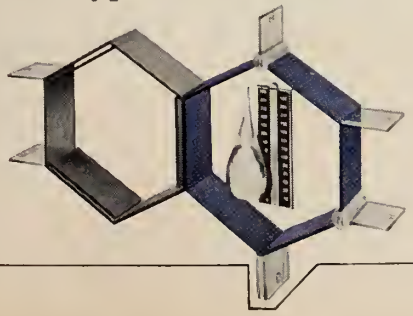
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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Brucella melitensis

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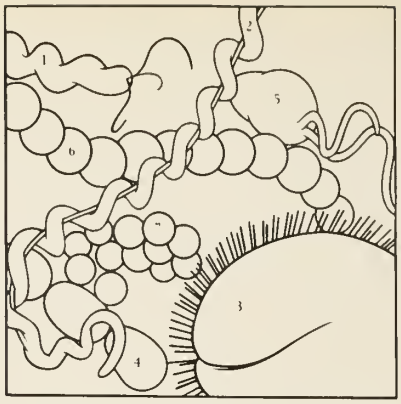
Leptospira icterohaemorrhagiae

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The microorganisms shown here—ranging from common to rare and refractory—demonstrate the wide spectrum of Terramycin (oxytetracycline) effectiveness.

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Diagrammatic key to microorganisms

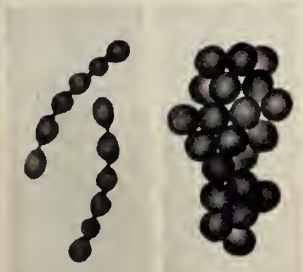
1. *Spirillum minus*
2. *Leptospira icterohaemorrhagiae*
3. *Balantidium coli*
4. *Brucella melitensis*
5. *Pseudomonas aeruginosa*
6. Streptococci
7. Staphylococci

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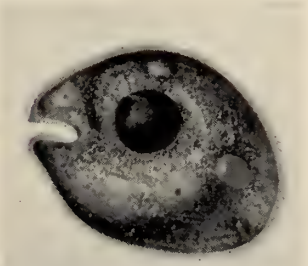
Streptococci Staphylococci

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Balantidium coli

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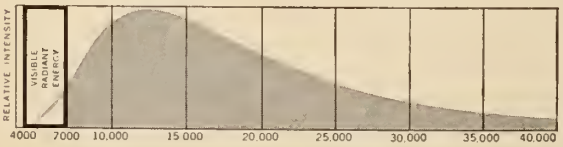
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NEWS BRIEFS

Robert D. Laird, M.D., Plymouth, recently joined Parke, Davis & Company as a medical investigator in the Research Laboratories at Ann Arbor. He formerely taught at Wayne State University and the University of Michigan; and was medical director of Sherman Laboratories, Detroit.

A new postgraduate course for doctors in general practice will be held at The University of Michigan Medical Center on December 3, 4 and 5. It is called "Otorhinolaryngology for Generalists" and will deal with the practical treatment of ear, nose and throat problems. Information may be obtained from Walter P. Work, M.D., chairman of the U-M Medical School's Department of Otorhinolaryngology.

Remus G. Robinson, M.D., Detroit, has been elected vice-president of the Detroit Board of Education. He also is chairman of the Board's school-community relations committee.

The community of Holt, south of Lansing, honored **F. L. Troost, M.D.,** at a civic reception for 30 years of service as team physician for Holt High School. He resigned the position last year. A portrait of Doctor Troost has been placed in the senior high building.

Several MSMS members presented papers at the annual convention of the American Roentgen Ray Society of Minneapolis. **Dr. William R. Eyler** and **Bernard M. Schuman,** Detroit, discussed "Radioiodinated Rose Bengal Liver Scan as an Aid in the Differential Diagnosis of Jaundice." **Drs. Fred J. Hodges, Walter M. Whitehouse** and **Arthur C. Kittleson,** of Ann Arbor, discussed "Video Tape Recording of Tracheo-Bronchial Dynamics." **Drs. J. V. Fayos, R. C. Hendrix, Isadore Lampe,** of Ann Arbor, covered "Hodgkin's Disease: A Clincopathologic Study."

Thomas French, M.D., will address the Detroit Psychoanalytic Society and Institute on "Psychoanalysis," at the McGregor Memorial Building, November 18.

An address about "Prophylaxis of Postoperative Pancreatitis" was given by **Nikolas Kazmers, M.D.,** Lakeview, before the Fourteenth Biennial Congress of International College of Surgeons in Vienna.

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Bernard Mandelbaum, M.D., Detroit, received the Grand Award in the intern-resident category for his scientific exhibit in the SAMA-Squibb awards program at the AMA meeting in San Francisco.

Harold F. Falls, M.D., Ann Arbor, will be the guest speaker for the Section of Ophthalmology of the Southern Medical Association, November 16-19 in Memphis.

Shirley Austin, M.D., Howell, is a member of the board of directors of the new Center for Continuing Professional Study at Brighton. The first activity will be a series of classes for nurses in eight of the larger Michigan counties. President of the Center's board is Theresa Phelps, former executive secretary of the Greater Detroit District of Nurses.

Wielding the gavel at the meetings of the Lansing Rotary Club is **William D. Cheney, M.D.,** as President. He has been a member of Rotary for nine years.

The six psychiatrists constituting the active medical staff of The Haven Hospital are teaching a class, "Psychological Aspects of Living" in the Continuing Education Program at Oakland University.

The regional meeting of the Michigan Education Association at Traverse City, October 1, included an address by **Warren Cline, M.D.,** Traverse City, to a health education conference.

David Wall, M.D., Marquette, was one of the speakers at the fall conference in Escanaba of the Upper Peninsula Chapter of the Council on Family Relations.

Alex S. Friedlaender, M.D., Detroit, was chairman of the 32nd Annual Balfour Concert presented by the Zionist Organization of Detroit, October 31, by Miss Roberta Peters and the Toledo Symphony.

The Manistique Senior Citizens Club heard **Duane Waters, M.D.,** speak about medical care to the aging.

Max K. Newman, M.D., Detroit, has been appointed to the National Board of Directors of the Muscular Dystrophy Association of America.

The new clinical director at the Newberry State Hospital is **William Blyth, M.D.,** a graduate of the University of Glasgow Medical School and long identified with psychiatry and mental hospital administration in Scotland.

Norman Rosenzweig, M.D., director of the Department of Psychiatry of Sinai Hospital of Detroit, has accepted the post of temporary psychiatric consultant to the Oakland County Mental Health Services Board. Dr. Rosenzweig will continue with his regular responsibilities at Sinai Hospital.

Re-elected as treasurer of the Grand Ledge Board of Education for his third term is **Gordon R. Harrod, M.D.**

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Parke, Davis & Company has appointed **John E. Gajewski, M.D.**, as Director of Medical Education and Editorial Services. In addition to medical correspondence activities and the medical editorship of Therapeutic Notes, Dr. Gajewski will continue to provide medical counsel for advertising and promotion projects and in the area of sales training.

Dr. Gajewski, of Grosse Pointe Park, joined Parke, Davis in 1949.

Under the direction of **Donald Damstra, M.D.**, Brighton, medical director for the Detroit Salvation Army, a "Heartmobile" is rolling on Detroit streets to give free cardiograms. The project seeks to detect heart disease in its early stages.

James T. Howell, M.D., Detroit, has been appointed chairman of the Professional Practice Committee of the American Hospital Association.

A special program by the Paw Paw Kiwanis Club honored **Charles TenHouten, M.D.**, who has stepped down after serving 12 years as the village president. A "Kiwanis Community Service Award" was presented to Doctor TenHouten.

Governor Romney recently appointed three MSMS members to the Michigan Youth Commission—**Robert M. Heavenrich, M.D.**, Saginaw, and **Irving Posner, M.D.**, Detroit, and **Eleanor Skufis, M.D.**, Adrian.

Also named was **Herbert A. Auer**, of the MSMS staff.

The first honorary membership ever awarded by the Muskegon County Medical Society has been conferred upon **Bob D. Dann**, superintendent for 26 years of the Hackley Hospital in Muskegon.

M. T. Batchelor, M.D., Detroit, is a new member of the Board of Trustees for Alma College.

On September 1, **Joseph V. Fisher, M.D.**, Chelsea, began a six-month study as a fellow in the department of psychiatry at the University of California Medical Center in San Francisco. The study is a grant from the National Institute of Mental Health.

George **Andrews**, former director of the Department of Adjunctive Therapies at Plymouth State Home and Training School, is the educational administrator of the new Division of Physical Therapy at Wayne State University's School of Medicine. Mr. Andrews received his M.S. in education at Syracuse University and his MA degree in education and a certificate in physical therapy at New York University.

Herbert M. Platter, M.D., Columbus, Ohio, was cited for his "Impact on American Medicine" when he was presented a plaque by **E. C. Swanson, M.D.**, Lansing, immediate past president of the Federation of State Medical Boards, during the Second Annual Scientific Awards Dinner of the AMA in San Francisco.

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Robitussin with antihistamine and codeine

Each 5 cc. (1 tsp.) contains:
Glyceryl guaiacolate . . . . . 100 mg.
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Codeine phosphate . . . . . 10.0 mg.
(Warning: may be habit forming)
Alcohol 3.5 per cent

Robitussin is indicated in coughs associated with head and chest colds, bronchitis, laryngitis, tracheitis, pharyngitis, pertussis, "flu," "grippe," measles, chronic paranasal sinusitis, pulmonary tuberculosis, or smoking. Robitussin A-C is especially indicated for allergic, harsh or unresponsive coughs.

dosage: ADULTS—1 tsp. every 3 to 4 hours. CHILDREN—½ tsp. every 3 to 4 hours.

side effects: No serious side effects from glyceryl guaiacolate have ever been reported. Nausea, G-I upset, and drowsiness may be encountered rarely with Robitussin A-C.

precautions: There are no contraindications for Robitussin. Robitussin A-C is contraindicated in patients hypersensitive to antihistamines or codeine.

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Alcohol 3.5 per cent in a palatable, aromatic base.

DIMETANE® EXPECTORANT-DC

(exempt narcotic)

antihistaminic / antitussive / suppressant

Codeine phosphate . . . . . 10 mg.
(Warning: may be habit forming)
Dimetane® (brompheniramine maleate) . . . . . 2 mg.
Phenylephrine hydrochloride . . . . . 5 mg.
Phenylpropanolamine hydrochloride . . . . . 5 mg.
Glyceryl guaiacolate . . . . . 100 mg.
Alcohol 3.5 per cent in a palatable, aromatic base.

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side effects: Overdosage may result in mild drowsiness or excitement, but within the therapeutic range neither is likely.

Precautions: Administer with caution to patients with cardiac or peripheral vascular diseases and hypertension.

contraindications: Hypersensitivity to antihistamines or codeine. Not recommended for use during pregnancy.

references:* Boyd, E. M., and Ronan, A. K.: Am. J. Physiol., 135:383, 1942.



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SCIENTIFIC PAPERS

CERVICAL SPINE AND SPINAL CORD INJURIES

By RICHARD C. SCHNEIDER, M.D.,
ANN ARBOR

During recent years, greater interest has been focused on simple cervical fractures and fracture-dislocations of the spine or those associated with spinal cord injury. It has become apparent that certain types of these lesions should be treated by the older conservative methods such as skeletal traction[1] or immobilization in casts or braces for they will heal without operative intervention, while others should have early surgical therapy consisting of decompression of the cervical spinal cord or nerve roots with or without spinal fusion.

This clinical material is presented briefly to aid in the clarification of these problems.

A very high percentage of cord injuries occur in the lower one-third of the cervical spine where the cervical enlargement of the spinal cord occupies proportionally more of the spinal canal than at the higher levels. Traumatic lesions in the lower one-third of the spine with concomitant spinal cord injury are unfortunately too often associated with marked and usually permanent neurologic deficit. In injuries of the upper one-third of the cervical spine when complete cord destruction is present, the patient often succumbs immediately since the intercostal and diaphragmatic muscles are both paralyzed resulting in respiratory arrest.

However, some of these patients with certain types of partial spinal injuries in this region due to compression of the cord or vascular insufficiency may survive if properly treated.

* * *

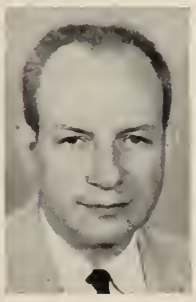
COMPRESSION FRACTURES OF THE cervical spine are most likely to occur at C6 and C7 vertebral body level where the markedly mobile cervical spine joins the upper thoracic region which is relatively well stabilized by the thoracic cage.

In general, cervical spinal cord injuries are more likely to occur in flexion than in hyperextension for the muscles involved in restriction of the latter movement are much more powerful and capable of resisting forced over-extension.

For this reason, for example, as a protective measure a football player should keep his head slightly upward and his cervical spine in mild hyperextension when making a tackle.

* * *

FINALLY, ONE MUST REALIZE there are a number of cervical spine and spinal cord injuries which are chronically progressive and whose symptoms develop insidiously. Only through *careful and*



Author
RICHARD C. SCHNEIDER
M.D.

From the Departments of Surgery, Sections of Neurosurgery, University of Michigan Medical Center and Saint Joseph Mercy Hospital, Ann Arbor, Michigan.

repeated radiologic and neurologic evaluations may the lesions be detected and correction of the spinal deformity and the spinal cord or nerve root compression be accomplished, thus preventing permanent neurologic disability.

The following case reports may present a better understanding of the clinical significance of these problems.

CASE REPORTS

Case 1.°—A middle-aged, left-handed man was involved in an automobile accident. X-rays of the cervical spine revealed an occipital-atlantal separation associated with disruption of the atlanto-occipital ligaments and a linear fracture of C4 spinous process (Fig. 1A). He had a compound fracture of the right mandible and his tongue was so severely lacerated that it required fifteen sutures to close the wound.

A tracheostomy was performed at a local hospital and the patient was transferred to the University of Michigan Medical Center for further treatment. The neck was swollen and tender, and a left pneumothorax was found which was successfully treated by intercostal suction drainage. His neurologic status was normal except for a right sixth cranial nerve palsy. Vinke tongs were inserted, and ten pounds of traction were used to stabilize his cervical spine. A week after injury he was moved to the U. S. Veterans Hospital, Ann Arbor, for further care. A cranio-cervical myelogram revealed a leakage of pantopaque anteriorly at the junction of the occiput and atlas with some defect in the anterior portion of the column due to posterior displacement of the atlas (Fig. 1B).

Comment.—This is the only fracture-dislocation of this type seen in the author's experience. There was a complete disruption of the anterior and posterior occipito-atlantal ligaments or such a lesion could not have occurred. Inasmuch as the vertebral arteries are captives as they cross the C1 lamina and enter the skull through the foramen magnum, this man could very readily have sustained marked hypoxia to his upper cervical cord and brain stem by torsion or compression of these vessels. Since he had a considerable amount of secretion of blood in his trachea from his lacerated tongue and there was a certain degree of hypoxia from his left pneumothorax, the tracheostomy no doubt was a life-saving measure.

The subsequent cervical myelogram demonstrating a definite disruption of the meninges with leakage of contrast material anteriorly through the anterior longitudinal ligament and through the capsule of the occipito-atlantal membrane is of some significance. Where such an iatrogenic dural tear occurs in operations on the lumbar region or on the suboccipital area, a tiny hole in the dura permits cerebrospinal fluid to push the arachnoid through the defect causing a ball-valve action thus creating a meningocele. The possibility of such a lesion occurring in this man must be seriously considered and therefore the author believes posterior exposure of the region by laminectomy with transdural inspection of the anterior dural defect should be considered prior to fusing the occiput and the upper two or three cervical vertebrae.[1,9] A cautious repeat cervical myelogram may be justified in such instances to determine the fate of this dural rent anteriorly.

Case 2.—A middle-aged, right-handed man was rendered unconscious during an automobile accident. He was taken to a local hospital where it was noted he had facial and head lacerations, a closed head injury, and fracture of his right clavicle. His lacerations were sutured and a tracheostomy was performed. The clavicle was treated in a figure of eight support. Because of his precarious condition satis-

°Courtesy of Drs. T. O. Gabrielsen and John A. Maxwell. To be published.



Figs. 1A and B. Case 1

Fig. 1A. The lateral x-ray view of the cervical spine shows complete disruption of the ligaments between the skull and the atlas (arrow).

Fig. 1B. A cranio-cervical myelogram demonstrates that laceration of the meninges has occurred with leakage of the pantopaque anterior to the junction of the skull and cervical spine. There is an anterior defect in the opaque medium caused by posterior displacement of the atlas. (Courtesy of Dr. Trygve O. Gabrielsen and Dr. John A. Maxwell. To be published.)



Fig. 2A, B and C. Case 2.

Fig. 2A. This lateral cervical spine film taken *with slight rotation* suggests an occipito-atlantal separation similar to that presented in Case 1.

Fig. 2B. This lateral x-ray view of the lesion shows a posterior greenstick fracture of the odontoid process *without* apparent occipito-atlantal separation.

Fig. 2C. A laminagram made after the application of skeletal traction confirms the findings in Fig. 2B, but shows some continued mild posterior odontoid displacement.

factory x-rays could not be procured but atlanto-axial dislocation was suspected in the x-ray films which were available.

Since he continued in a comatose state for a week without any change in his vital signs, the patient was transferred to the University of Michigan Medical Center a week after injury. On admission to this hospital he was semi-comatose so that only marked pressure upon the supraorbital notch caused extension of the hands and arms in a "flipper" position (i.e., the fingers, hands, and arms went into extension with the hands in ulnar deviation) in a pattern of decerebrate rigidity. No definite sensory change could be elicited. There was anisocoria with the left pupil slightly larger than the right, and he had an equivocal right facial paresis. There were bilateral extensor plantar reflexes but there was no evidence of pyramidal tract signs in the upper extremities.

X-rays of the skull and cervical spine suggested a possible occipito-atlantal separation, and a linear fracture of the laminar arch of the atlas, and a rather marked posterior atlanto-axial dislocation (Fig. 2A). A repeated x-ray examination disclosed only the lateral abnormality (Fig. 2B). Vinke skeletal traction was applied and the patient placed on a Foster frame with the cervical spine in slight flexion and eight pounds of traction were applied in an attempt to realign the spine.

Neurologic re-evaluation three days after transfer to Ann Arbor demonstrated that with painful stimuli the patient's arms moved into flexion with clenching of the fists but his state of consciousness remained unchanged. Laminagrams were secured to disclose the condition of the cervical lesion. The odontoid process was not in perfect position but had the appearance of a greenstick fracture which was about 75 per cent reduced and in fair alignment (Fig. 2C). Arteriography was performed to exclude the presence of an intracranial lesion.

Comment.—Posterior atlanto-axial dislocations are relatively rare compared to the number of anterior ones. Unfortunately, because of the patient's semi-comatose state, the classical "open-mouth" x-ray views of the odontoid process could not be obtained. The lacerations on the head and face suggested the mechanism of injury in such instances was one of severe hyperextension of the cervical spine with the greenstick fracture occurring at the base of the odontoid process. The recognition of the neurologic signs of rigid extension of the upper extremities with the hands in the "flipper" position and yet preservation of voluntary flexion movements of the lower extremities is of importance for it suggests a high cervical cord or lower medullary injury due to direct spinal cord compression or some compromise of the vertebral artery blood supply to these regions.[18] These findings may be contrasted to the similar pattern of the upper extremities with marked extension of both lower extremities and opisthotonos as is witnessed in midbrain injuries. The prognosis in our experience has been much better in the former group

of patients. Preferred treatment is tracheostomy and the application of skeletal traction in some degree of flexion to re-establish alignment, and usually posterior fusion to include the occiput and the upper cervical spine.[9]

Case 3.—A 20-year-old man was involved in an automobile accident in September, 1952. At this time, he sustained a fractured nose and severe soft tissue injuries of his face. Immediately after the accident, he had some stiffness of his neck and x-rays taken at a local hospital were reported to have been normal. He was released from medical care but continued to have stiffness and aching in his neck which was accentuated by rotating and flexing his head forward. He was examined at University Hospital on February 6, 1953, and found to have limited flexion and extension of neck movements. Forced flexion or compression of the cervical spine caused moderate pain over the upper cervical region, and there was slight tenderness on palpation. He had no neurologic deficit.



Fig. 3A. Case 3. The "open mouth" view shows the complete avulsion of the dens from the axis.

X-rays of the cervical spine disclosed a complete avulsion of the odontoid process from its base on the "open mouth" views (Fig. 3A). The lateral views in flexion showed the degree to which displacement of the dens had occurred (Fig. 3B and C). They also display nicely the approximation of the atlantal arch to the occiput a point repeatedly emphasized by Badgley.[2] Vinke skeletal tong traction was applied and the patient was placed on a Stryker frame. On February 19, 1953, an arthrodesis of the occiput and the first three cervical vertebrae was performed by Dr. Carl Badgley of the Orthopedics Department (Fig. 3D). The patient remained on the frame posteriorly until March 7, 1953, at which time a Taylor back brace and Forrester collar were substituted for the traction apparatus. The patient made an uneventful recovery and sustained a solid fusion.

Comment.—This patient was interesting for he displayed the more common classical anterior atlanto-axial dislocation with fracture of the odontoid and dislocation anteriorly rather than posteriorly as described in the previous case. The classical "open mouth" view demonstrated nicely the complete avulsion fracture of the odontoid process from its base on the axial body. As in the previous



Fig. 3B, C and D. Case 3.

Fig. 3B. Anterior dislocation of the atlas on the axis in the flexion view. Note the approximation of the atlantal arch to the rim of the foramen magnum.

Fig. 3C. The anterior dislocation lesion demonstrated on the hyperextension view.

Fig. 3D. Postoperative film demonstrating partial reduction and posterior arthrodesis incorporating the occiput with C1, C2 and C3 processes and lamina.

instances, there had been a facial injury, but in this case no period of unconsciousness to suggest that skull x-rays should have been taken. It was amazing the degree to which such anterior dislocation of the atlas could occur without symptoms.[6,7,8] The author has called attention to the significance of such a lesion in a football player where an acute dislocation of this type probably compressed the vertebral artery bilaterally causing hypoxia to the brain stem resulting in convulsions, respiratory failure, and death.[19] The chronic development of such lesions has prompted the author to include cervical spine and x-ray examinations in many cases of head injuries. It is remarkable how insidious they may be.[2,10]

Case 4.—A ten-year-old boy was struck by a car at 5:15 p.m. On admission to the hospital he was unconscious and in decerebrate rigidity. There was an eight centimeters in diameter cephalohematoma over the right occiput. His pupils were equal and reacted to light but his eyes were held in conjugate deviation toward the left side. X-rays of the skull exhibited an equivocal fracture of the right parieto-occipital area. He was given tetanus toxoid, penicillin, and Decadron. At 7:30 p.m., two hours after admission to the hospital, he displayed extension of his arms and some purposeful flexion movements of his lower extremities. A hypothermia regime was instituted. After eight days, his decerebrate state disappeared and he started to move about purposely, speech returned and he accepted oral fluids. The patient required an indwelling catheter for 34 days. Gradually, he ambulated and by June 3 he appeared to be neurologically negative and was discharged from the hospital. When seen by the neurosurgeon at the time of his follow-up visit the patient had a stiff neck and the tilt of the vertex of the head to the right with the chin toward



Fig. 4A. Case 4. The stiff head tilt of the vertex to the right with the chin toward the left classically suggests unilateral dislocation of the cervical facets.

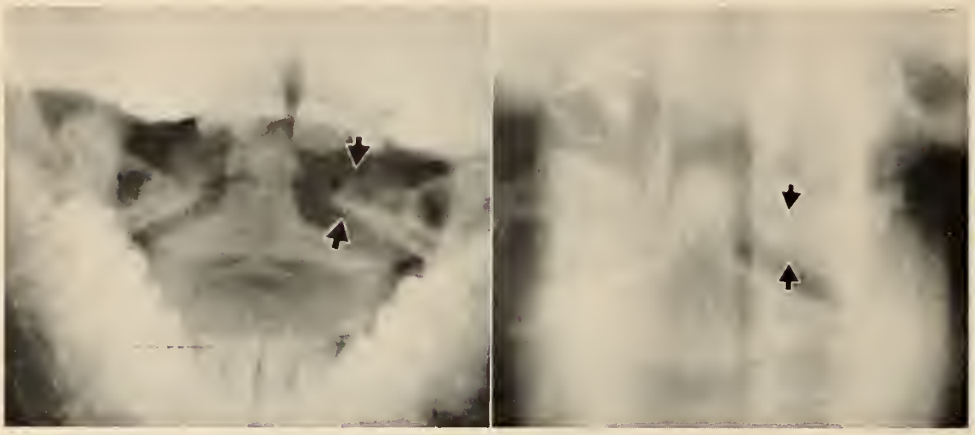
the left side (Fig. 4A). A diagnosis of unilateral dislocation of the upper cervical spine was made. The patient was admitted on the Bone and Joint Service under Dr. Gerald O'Connor's care. Lateral x-ray films of the cervical spine disclosed evidence of rupture of the transverse odontoid ligament so the ring of the atlas was anteriorly displaced (Fig. 4B). Routine "open-mouth" views of the odontoid process demonstrated that its base was intact. (Fig. 4C) Arrows designate the left lateral mass which does



Fig. 4B and E. Case 4.

Fig. 4B. There has been rupture of the transverse ligament. The space between the anterior "ring" of the atlas and the odontoid may be measured between the arrows. Badgley[2] has often remarked concerning the approximation of the C1 spinous process to the occiput and the distance between the C1 and C2 spinous processes in such cases.

Fig. 4E. Postoperative x-ray showing wire holding C1 and C2 spinous processes in apposition. Onlay autogenous bone is not visualized readily.



Figs. 4C and D. Case 4.

Fig. 4C. The routine "open mouth" views disclose no fracture at the base of the odontoid. Arrows indicate the left lateral mass.

Fig. 4D. Laminagrams of the previous view demonstrate a compression fracture of the left lateral mass.

not appear too abnormal compared to the right one. However, laminagrams revealed a compression fracture of the lateral mass (Fig. 4D), not readily visualized by other views. Vinke tong skeletal traction was inserted by the Neurosurgical Service and seventeen pounds of traction applied. Relocation of the spine was gradually accomplished and the patient was fused by the Bone and Joint Service two months after injury by Dr. Robert Bailey by wiring the spinous processes of C1 and C2 together and placing an autogenous bone graft posteriorly (Fig. 4E). The patient has made an excellent recovery.

Comment.—This case again indicates the problems of combined head and spinal cord injuries, and shows the pattern of high cervical cord injury vs. brain stem damage as described in the previous case. Because of the severity of the head injury, the spinal cord injury was masked. The "so-called" classical clinical picture of a unilateral fracture-dislocation of cervical facets is shown,[11,12] but in this case is due actually to a unilateral fracture of the lateral mass of the vertebral body with rupture of the transverse ligament. The value of the laminagram has been well demonstrated in this case. O'Connor has stressed the problems in diagnosis of traumatic lesions in this category which are ex-



Fig. 5A, B and C. Case 5.

Fig. 5A. The typical "hangman's fracture" of bilateral avulsion of the axial neural arch and dislocation of the axis on C3 vertebral body.

Fig. 5B. Post-traction laminagrams demonstrate reduction of the lesion with spinal realignment.

Fig. 5C. The normal lateral x-ray view post-reduction film is a contrast to the laminagram (Fig. 5B). (Courtesy J. Neurosurg., 1964.)

tremely difficult for even the best trained radiologists, orthopedic surgeons, and neurological surgeons.

Case 5.°—While asleep riding in the front seat of a car, an elderly man sustained a head and neck injury in an auto accident on November 24. He had no recollection of his surroundings until four or five days after admission to his local hospital. In addition to pain and limitation of motion of his neck, there was an open wound on the left side of the neck and lung emphysema. A severe laceration of the tongue required fifteen stitches. The cervical spine x-rays demonstrated a bilateral axial avulsion fracture of the neural arch and a dislocation of the axis on C3 vertebral body (Fig. 5A). He had no neurologic deficit. Tracheostomy was performed to combat tracheal compression and prevent aspiration of secretions. Skeletal tong traction was applied and in the succeeding days the patient gradually improved so the tacheostomy tube could be removed. He was transferred to University Hospital on December 27.

Subsequent cervical spine laminagrams were made and showed the fracture to advantage (Fig. 5B), confirming the excellent position visualized on the plain lateral x-ray views (Fig. 5C). The anterior-posterior view of the laminagrams indicated the odontoid process was intact. The orthopedic consultant recommended a cervical brace be substituted for the skeletal tong traction on January 7, six weeks after his injury. The patient was told he would have to wear this support for at least another eight weeks in order to permit stabilization of his fracture. It was removed on April 10 after x-rays showed continued good healing.

Comment.—This rather interesting type of fracture has been designated as a "hangman's fracture."[21] It is characterized by the avulsion fracture of the axial neural arch fortuitously resulting in decompression of the spinal cord. There may be some degree of dislocation of the axis on the C3 vertebral body. The lesion has been so designated since it was discovered that in most judicial hangings where a submental knot is used the cervical spine will exhibit this type of fracture. In the vast majority of instances, when it is the result of traffic accidents and survival occurs, it is associated with no neurologic deficit, and even more important, if properly immobilized for a sufficiently long interval will heal spontaneously without surgical intervention.[21]

Case 6.—A young, right-handed boy dove into shallow water and upon rising to the surface was reported to be immediately and completely paralyzed. He was cautiously removed from the water and taken to a local hospital where he was found to have a complete tetraplegia. Proprioceptive and superficial touch sensations were preserved throughout the body and all four extremities, and priapism was present. Cervical spine x-rays demonstrated a compression fracture of C4 vertebral body. These were procured in both extension and flexion positions to check on stability of the spine (Fig. 6A and B) and the dislocation treated by immobilization in a cervical collar.

His physician believed he had spontaneously reduced his lesion in the water. After the patient was catheterized the priapism disappeared. The patellar and Achilles reflexes were equal and active; the biceps and triceps reflexes were present but symmetrically diminished. He had no pathological reflexes.

Initially, transportation of the patient was considered dangerous, but after eighteen hours had elapsed and the patient had progressed to a complete motor and sensory

°Republished courtesy of J. Neurosurg., 1964.



Figs. 6A and B. Case 6.

Fig. 6A. The C4 vertebral body compression fracture is shown in flexion.

Fig. 6B. In hyperextension to the presence of a "tear drop" fracture of the C4 body is demonstrated with no apparent posterior displacement into the cervical spinal canal.

lesion, a neurosurgical consultant indicated that cautious transferral in traction to the University of Michigan Medical Center was advisable. Upon his arrival there the patient had a temperature of 106.2°, diaphragmatic breathing, and complete motor and sensory tetraplegia. Vinke skeletal tongs traction was inserted and 15 pounds of weight were applied. After 12 hours of vigorous treatment with alcohol sponges and suctioning his temperature dropped fluctuating in a range of 98° to 102°. His Achilles reflexes returned and there was plantar flexion on stroking the feet. The initial pattern suggested the typical acute anterior cervical cord injury syndrome and since his lesion was incomplete operation was considered.

A week after injury, he had a laminectomy of C3, C4 and C5 vertebrae. Upon opening the dura the spinal cord was found to be intact but discolored with a bluish cast suggesting rather marked contusion. The dentate ligaments were cut. No attempt was made to manipulate the cord and explore anteriorly for fear of causing increased damage and respiratory arrest. Approximately one month after injury he had an anterior spinal fusion by Dr. Bailey of the Orthopedic Staff to insure stabilization of the spine in the event that further neurologic return might occur.

About three months later, Dr. Bruce Stewart of the Urology Department diverted his urinary stream by a cutaneous vesicostomy. He has continued neurologically unchanged plagued by the usual complications associated with the tetraplegic state.

Comment.—This patient sustained a C4 vertebral body compression fracture which is at an extremely high level for such lesions. As has already been indicated, these usually occur at the junction of the mobile cervical and relatively fixed thoracic spines. Because of his level of combined spinal and cervical cord injury, his situation was marginal. The intercostal musculature had already been paralyzed and his local injury suggested the possibility of ascending edema impairing the C2, C3 and C4 nerve roots which would paralyze the diaphragm bilaterally with respiratory arrest. The cervical spine x-rays in mild flexion and limited extension showed there was no associated dislocation and a compression fracture was the underlying lesion. *In such instances, it is advisable to maintain the patient in traction in a neutral position during diagnostic studies.* Subsequent neurologic evaluation showed an incomplete lesion which had progressed after 18 hours into a complete one. The local physician used excellent judgment in not transferring this patient initially because of the high level of the cervical lesion, and by his careful neurologic follow-up examination picked up the progression of neurologic deficit. At this time, after the consultation with the neurological surgeon, it was realized the patient would have to be transferred *cautiously* for further therapy.

Because of the patient's high temperature and evidence of ascending cervical spinal cord edema, even a lumbar puncture was deferred 24 hours. When it was finally performed, there was no evidence of block on the Queckenstedt test and a cloudy pink fluid was obtained demonstrating subarachnoid hemorrhage from a probable laceration of the cord thus suggesting a very poor prognosis. Nevertheless his original physiological state had suggested the presence of an incomplete lesion of the acute anterior cervical spinal cord injury syndrome[13,15] and operation was performed. This syndrome consists of an immediate complete paralysis of all four extremities with a sensory pattern for pain and temperature consistent with the level of the lesion, but with the preservation of motion, position, vibration, and touch sensation. It may be associated with anterior cervical cord compression (by a ruptured disc or bony fragment), by anterior cervical spinal cord vascular insufficiency due to compression of the anterior spinal artery, or by partial anterior cervical spinal cord destruction. Since one cannot distinguish one type of lesion from another, decompression and exploration are indicated. After a week, the patient's state had stabilized sufficiently so that cervical laminectomy could be performed with exposure of the cord and section of the dentate ligaments. The bluish tinge of color in the cord indicated severe contusion and suggested that not only would manipulation of the cord not contribute any improvement but indeed could readily result in a fatality. Rehabilitation measures are being instituted but the prognosis for further recovery is extremely grave.

Case 7.—A young right-handed boy dove into shallow water and sustained immediate paralysis of all four extremities. He was admitted to a local hospital in a distant city where it was noted that touch, motion, and position sensations were preserved. Lateral x-rays of the cervical spine demonstrated a "tear drop" fracture of the C5 vertebral body (Fig. 7A). He was placed in skeletal traction and nine days later was flown to the University of Michigan Medical Center for further treatment. Upon admission to the hospital, he had a complete areflexic tetraplegia with hypesthesia in the C7 and C8 dermatomes and a level of T7 hypesthesia on the trunk bilaterally.

Touch and position sensations were well preserved on the left but less well so on the right side. There were no pyramidal tract signs. A lumbar puncture was performed with a partial block on the Queckenstedt test and a partial injury to the cervical spinal cord was diagnosed. Ten days after being placed on a Foster frame with 15 pounds of traction, he was operated upon at the level of C5 and C6 vertebrae. C5 spinous process was displaced approximately 1 centimeter from its normal position and there was a vertical fracture of the lamina of C5 bilaterally with some pressure upon the dura.

Laminectomy of C5 and C6 was performed with an elevation of the depressed spinous process and lamina. This was associated with a fairly extensive hemorrhage. Upon opening the dura the spinal cord appeared to be normal, and after sectioning the dentate ligaments it was believed advisable to leave this covering open. The right C6 nerve root had been partially divided by the trauma by the acute hyperflexion of the cervical spine. The left C5 and C6 nerve roots were bound down firmly and it was impossible to free them without producing further neurologic damage.

Forty-eight hours postoperatively, it was observed the sensory level had dropped 4 inches to the mid-scapular area and there was now a weak bilateral ankle jerk with a clonus of the right ankle. Inasmuch as the lesion was in-



Figs. 7A and B. Case 7.

Fig. 7A. There is a typical "tear drop" fracture of the fifth cervical vertebra caused by severe flexion. The anterior portion of the vertebral body drops off anteriorly, but the posterior fragment becomes displaced into the cervical spinal canal (arrow) with the possibility of causing anterior cervical spinal cord compression.

Fig. 7B. Anterior cervical spinal fusion of C4, C5 and C6 vertebral bodies to prevent further collapse, deformity, and possible cord compression.

complete, stabilization of the spine was thought advisable to prevent incomplete healing of the bone and kyphos formation with anterior spinal cord compression.

Twenty-three days after injury, an anterior cervical spinal fusion from C4 through C6 vertebrae was performed by Dr. Robert Bailey (Fig. 7B), and simultaneously Dr. Bruce Stewart made a suprapubic cystotomy which seven weeks later was followed by a vesicostomy. After nine months of convalescence, the patient has exhibited no further signs of recovery.

Comment.—This patient presented the anterior cervical spinal cord injury syndrome which also was noted initially in the previous case. It is highly doubtful that an earlier surgical attack on this problem would have been beneficial. However, Tarlov[22,23] has stressed in the experimental animal and man the longer compression has occurred the less chance there is for functional recovery. For this reason, the author would have operated on the patient as soon as possible after injury. His lesion was one cervical vertebral body lower than in the previous case and in such instances there is less danger of interfering with diaphragmatic function than in the previous one (Case 6). The importance of the "tear drop" fracture has been stressed by our neurosurgical service for it has been found such lesions have been extremely unstable.[16] In order to prevent further collapse of the vertebral bodies with kyphos formation, loss of lordotic cervical curve, and anterior cervical cord compression, anterior cervical spinal fusion was recommended. The prognosis for this patient is extremely grave for any further degree of recovery.

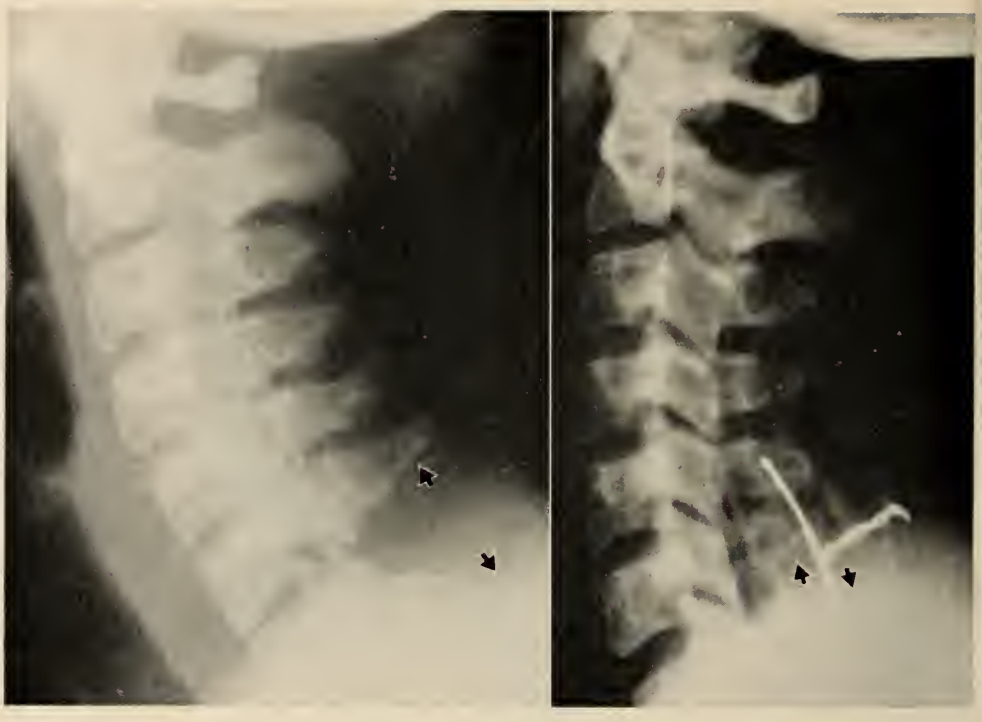
Case 8.—A right-handed, high school football halfback, while carrying the ball, received a neck injury when two tacklers held his arms at his sides while he fell forward with his head bent downward. A third opponent struck this group so that the ball carrier fell forward with the neck so completely flexed the head was markedly bent and both shoulders rested directly on the ground. The halfback had an immediate complete paralysis of all four extremities with a total loss of sensation for a few minutes after injury, but then he began to move his lower extremities.

From the time of injury until admission to his community hospital, the patient gradually recovered all motor power and noted pain and tingling only radiating along the inner aspect of his forearm. After having cervical spine x-rays, he was placed in halter traction at a local hospital for five days and then discharged wearing a plastic collar.

Five weeks later, a neurosurgical examination at the University of Michigan Medical Center revealed some right triceps paresis and weakness of his interosseus muscles. X-rays of his cervical spine demonstrated dislocation of C6 on C7 vertebral body with marked subluxation of the facet bilaterally and marked separation between the C6 and C7 spinous processes (Fig. 8A). A fracture of the lateral mass of C7 and possibly C6 vertebrae was demonstrated on the steroscopic views.

On the following day, Vinke tongs were inserted and skeletal traction was applied. The author exposed the C6 and C7 facets two days later and a subtotal laminectomy with partial facetectomy was performed at C6-C7 on the right side. The nerve root at this interspace was exposed and was found to be compressed at the foramina of C6-C7 with most marked impairment on the right side. A right foramenotomy was performed with decompression of the involved nerve root. Dr. Robert Bailey of the Bone and Joint Service then inserted a No. 18 wire through the C5 and C7 spinous processes and the latter was tightened. The C5, C6, and C7 lamina were roughened and cancellous bone slivers from the Bone Bank were applied over this area bilaterally and the wound closed.

A recheck examination of the cervical spine taken 12 days later demonstrated the wire and the posterior cervical fusion (Fig. 8B). Nine days later, the skeletal traction was



Figs. 8A and B. Case 8.

Fig. 8A. The subluxation of the C7 superior articular facet on the C6 inferior anticular facet is well visualized. The amount of displacement is apparent when the degree of interspinous spread is noted (arrows).

Fig. 8B. Postoperative reduction of the subluxation has been accomplished by traction (which should have been diminished). The wired C5 and C7 spinous process and cancellous posterior arthrodesis are shown.

removed, a Forrester collar was applied for three more days, and he was discharged from the hospital.

Comment.—This injury occurred in the position of flexion and the football player was extremely fortunate not to have totally transected his cervical cord. He sustained either a transient concussion of the cervical spinal cord or there was transient vascular insufficiency to it for he recovered complete function. The C7 nerve root was adequately decompressed and it is very likely he will make a complete recovery. This type of lesion has been seen by the author on several occasions. It may be insidious and gradually progressive. Serial post-injury x-ray examinations are the only method of excluding such gradual progressive subluxation without neurologic deficit. In this instance, cautious decompression of the nerve root and realignment of the cervical spine with stabilization by posterior cervical spinal fusion is the treatment of choice. The prognosis for complete recovery is excellent.

Case 9.—A middle-aged man was riding in a boat in the spring of 1960 when he struck his head as he was passing under a low bridge and sustained a three-inch forehead laceration and an injury to his neck. Upon being taken to the local hospital, x-rays of the cervical spine were reported as negative (Fig. 9A). He was never rendered unconscious and after examination he was released from the hospital and able to drive his car home. Over a period of a few days, he noted some progressive numbness on the ulnar side of both arms and complained of pain in his neck and coldness of his hands. Cervical halter traction was attempted intermittently at home and in the hospital without much relief of his pain. Most of his symptoms were attributed to his excessive chronic ethyl alcohol intake. Three weeks after his injury he developed progressive weakness in his grip bilaterally, was unable to extend the ring and the little fingers of his hands, with more involvement of the left extremity than the right. The patient also observed that his hands were dryer, and lying down seemed to relieve the pain in the neck. On the day after the accident, he was catheterized for urinary retention and thereafter he was able to void. He gradually observed some progressive pain in his lower back with radiation into both lower extremities when he coughed. A month after his injury, he was referred to the University of Michigan Hospital for further evaluation and treatment. At the time of his hospital admission he had weak triceps function bilaterally; extension of the wrists and fingers was absent; the grip was paretic, particularly in the right hand; the interosseus muscles were weak bilaterally and there was no approximation of the thumb to the other fingers. Atrophy was noted in the triceps and interosseus muscles in both upper extremities. The triceps reflex was symmetrically absent and the biceps reflex was weakly present bilaterally. Hypesthesia was present in C6 and C7 dermatomes on the right side and in the left C8 dermatome. Skeletal traction was applied and the patient placed on a Foster frame. A

lumbar puncture demonstrated no block on the bilateral jugular vein compression test. An electromyogram showed very marked denervation in all muscles supplied by C6, C7 and C8 nerve roots. Transaxillary views of the cervical spine demonstrated a dislocation of C7 vertebra on T1 vertebral body (Fig. 9B and C).



Fig. 9A. Case 9. This initial lateral x-ray film failed to demonstrate the base of the C7 vertebral body and its site of fracture-dislocation on the first thoracic vertebra. The arrow indicates the fractured C7 spinous process.

Five weeks after the initial injury at the time of a decompressive operation by Dr. Carl E. Badgley and the author, the C7 spinous process was found to be fractured. A complete laminectomy of C6, C7 and T1 vertebrae bilaterally was accomplished. The spinal cord was found to be markedly compressed anteriorly. The C7 and C8 nerve roots were severly pinched between the locked facets of C7 and T1 vertebrae. These nerve roots were unroofed and bone cautiously chiseled away under them accomplishing a marked degree of decompression, but the prognosis for any recovery was considered guarded since the C8 nerve root seemed to be scarred and somewhat frayed. In order to achieve a more complete decompression of the roots, a part of the facets of C7 and T1 were deliberately removed. The dura was opened, the dentate ligaments sectioned, and the spinal cord allowed to move freely posteriorly. The wound was then closed.

The patient's postoperative course on a Foster frame in traction was uneventful except for pain in the neck and arms. Because of the intentional facet removal at the time of the initial procedure, an anterior cervical spinal fusion was performed, two weeks later by Dr. Robert Bailey of C6, C7 and T1 using an iliac bone graft. Following his operation, the patient seemed well except for some right vocal cord paresis. Three or four weeks after his initial surgical procedure, he began to have increased function in the intrinsic muscles of his hands.

When seen six months after his injury, the patient had made remarkable progress toward recovery. His sensation had returned almost completely to the right hand and hypesthesia was confined to the left C8 dermatome. The interosseus muscles were weak, the biceps muscles were strong and the triceps were paretic bilaterally. The appearance of his anterior spinal fusion was reported as being



Figs. 9B and C. Case 9. The value of the transaxillary view of the cervico-thoracic junction is well demonstrated.

Fig. 9B. The arrows designate the margins of the C7 spinous process fracture.

Fig. 9C. The arrows indicate the posterior margins of C7 and T1 vertebral bodies, respectively. At this site such a degree of fracture-dislocation without spinal cord damage is truly remarkable.

solid. A note three years after injury indicated the man was working and had fair function of his hands but that he still had radiating radicular pain relieved by empirin compound and codeine. The status of his alcoholic intake was not stated.

Comment.—This patient illustrates several important principles. The x-rays of the cervical spine should always demonstrate the relationship of the C7 to T1 vertebral body in cervical spine injuries. The transaxillary lateral x-ray view of the cervicothoracic junction may be necessary to accomplish this. Posterior operative decompression of the nerve roots in cervical spinal cord in these cases is necessary. Simple anterior cervical spine exposures with subsequent fusion initially would have been inadequate to view the extent of this problem. The facets had to be removed deliberately posteriorly to achieve adequate decompression of the nerve roots, and the dentate ligaments sectioned to free the cervical cord. On the other hand, a posterior exposure with decompression of the cervical cord and nerve roots alone would not have sufficed. The anterior cervical spinal fusion was necessary secondarily to stabilize the spine which had been made unstable by the initial deliberate facetectomy.

Case 10.—A 34-year-old, right-handed carnival performer known as a "cannon ball" was admitted to University Hospital on July 14, 1950, after sustaining an injury when he was shot out of his cannon over two ferris wheels 80 feet high into a net 240 feet away (Fig. 10A). One of the net's supports broke so that the performer struck the ground on his chest and side of his head. He was temporarily rendered unconscious. Upon being removed to the hospital, he kicked his feet and became slightly violent but seemed to recognize his friends. X-ray films of the cervical spine showed a fracture-dislocation of C6 vertebral body on C7 (in 1950 in the *wet x-ray films* the detail was not clearly visible) (Fig. 10B). The neurosurgical resident promptly applied Crutchfield skeletal traction and the patient was placed on a Stryker frame.



Fig. 10A. Case 10. The "human cannon-ball" in full flight rocketing 80 feet in the air finally to land in the net 240 feet away. (Usually, there are two ferris wheels, over which the performer is catapulted.)

During the night, the patient was irrational and did not respond well to commands. His right pupil reacted to light but his left could not be visualized due to the swelling of the face. His vital signs remained unchanged. Forty-eight hours after injury it was confirmed that the patient had sustained a cervical spinal injury two years previously and



Figs. 10B and C. Case 10.

Fig. 10B. This lateral x-ray film of the cervical spine was taken on August 15, 1950.

Fig. 10C. The second lateral x-ray view demonstrates the appearance on admission to a hospital on July 19, 1948.

his x-rays were procured from a distant hospital (Fig. 10C). In spite of the fact that he had been advised to wear a collar, he had taken it off in two or three weeks, returning to his beloved cannon, and apparently had pounded himself into a solid union, fortunately without associated spinal cord injury.

The patient's state of consciousness seemed to be lightening slightly by July 23, 1950, but he still remained disoriented, confused, and mumbling. A cautious lumbar puncture revealed a xanthochromic cerebrospinal fluid under normal pressure. During the next three days, the patient developed bilateral horizontal nystagmus, and observers believed he was less responsive. Because of his impaired state of consciousness and the progression of neurological signs in the form of nystagmus, a posterior fossa clot was suspected and a ventriculogram made on July 27. This showed normal sized ventricles without any evidence of an expanding lesion or hydrocephalus. Instead, there seemed to be some degree of left cortical atrophy.

His mental state began to clear satisfactorily and he was discharged on July 30 to his local hospital for further care. When seen on follow-up examination some weeks later, the patient was still found to have nystagmus and a marked organic brain syndrome. At this time, he notified the examiner that he had had the "dancing eyes since birth!"

He effusively thanked the author for saving his life, and thereafter annually presented him with two tickets to his performance at the local State Fair, in spite of the fact that he had been advised to refrain from his occupation.

Comment.—This case is presented to demonstrate how adherence to a code of indications for operation based on neurologic signs alone may lead one astray if an adequate history of an injury cannot be procured. In these days, the "wet reading" x-ray misdiagnosis is no longer a problem in most institutions since there are new dry machine methods of developing films. The "cannon ball" was one of the most vigorously treated patients and a most grateful one.

DISCUSSION

These ten cervical spine injury cases have been carefully selected to indicate the problems related to diagnosis and treatment. It is apparent that there was little or no difficulty acutely in identifying the lesion in Cases 1, 2, and 5 and proceeding with immediate therapy. The lessons related to the proper method of diagnosing a lesion by x-ray are taught in Case 6 where flexion and extension films were made. In such instances there is a possibility of causing increased spinal cord edema and perhaps a progression of neurological deficit. All of these patients preferably should be transported in halter or skeletal traction, or, if this is absolutely impossible, should be immobilized carefully with the head and neck firmly held in a neutral position with the aid of sand bags. The chronicity of symptoms or their progression merits urgent consideration for in Cases 3, 4, 7, 8, and 9 the initial routine x-ray examinations of the cervical spine were either inadequate in demonstrating the lesion clearly, or special views such as "open-mouth" (Cases 3 and 4), laminagrams (Cases 4 and 5), or transaxillary views (Case 9) were necessary. *The latter examination is most important for it is imperative the relationship of the C7 vertebral body to the first thoracic vertebra be visualized in all patients when cervical spine injuries are suspected.* In these days, it is unlikely there will ever be difficulty in identifying an old cervical fracture-dislocation such as the one diagnosed as an acute lesion in the "wet reading" (Case 10).

Fortunately, in this country, the pre-World War II era of complete conservatism in the treatment of spinal cord injuries, namely, of only placing a patient in a brace, halter, or skeletal traction has gradually faded. Throughout the past two decades the realization has occurred that treatment of the bony lesion was not enough but some consideration of the condition of the spinal cord was important. Based on the condition of the cervical spine and the patient's neurologic deficit, definite surgical indications and contraindications have evolved which may aid the surgeon in determining the type of approach which is required for the individual case.[14,17,20] In general, these criteria are too involved for a general discussion of this type.

Finally, a word should be said about the operation. In cases of atlanto-axial dislocation, healing may not occur without adequate stabilization by posterior fusion using wire, acrylic, or bone.[3] In lower cervical injuries anterior fusion, a simple procedure, not only does not permit adequate extradural and intradural exploration of the cervical segments involved, but also it does not allow section of the dentate ligaments to aid in decompression of the cervical spinal cord. Its attraction lies in the fact that it does not require the more delicate technique of the posterior approach in which the spinal cord and nerve roots must be handled with gentleness or serious neurologic deficit will occur. But it affords a shorter and usually more comfortable convalescence. There is a definite place for both the anterior and the posterior surgical treatment of spinal cord injury. Before the innovation of anterior fusion, the surgeon avoided facet disruption in decompressive laminectomies when exploring extensively extradurally and intradurally lest cervical spine dislocation occur. The posterior exposure of the cervical spinal cord may now be more radical in procuring adequate visualization with-

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out as great fear of instability, for anterior cervical fusion may be performed as a secondary procedure for fixation purposes. This is particularly true in the cases of "tear-drop" fracture-dislocation.

SUMMARY

Ten cases of cervical fracture-dislocation have been presented demonstrating which types of lesion may be treated conservatively by traction and bracing, and which patients require posterior exploration with or without posterior fusion or combined anterior cervical spinal fusion.

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New Surgeon General Policy re Polio Vaccine Outlined by Doctor Heustis

The following statement re "Immunization Policy re Polio Vaccine" has been issued by Albert E. Heustis, M.D., State Health Commissioner:

Mass Immunization Programs in the Absence of an Epidemic

"Communities which have not yet embarked on mass immunization programs, and which after proper counsel with health authorities decide to do so, should carry out such elective mass programs during the late fall, winter, and early spring to avoid failure of immunization in persons who may have interfering enteroviruses. The Public Health Services states:

" 'Such programs will be of value only if they succeed in reaching unimmunized persons, particularly preschool children, in lower socioeconomic areas. Before embarking on mass programs, all communities should develop definitive plans for continuing immunization programs to care for the new susceptibles born into or moving into the community.'

"Attention is invited to the following statement which appeared among the recommendations of the Special Advisory Committee on Oral Vaccine to the Surgeon General of the Public Health Service, released on September 22, 1964:

" 'The age groups to be immunized in mass programs and the vaccine chosen for use should be determined locally. The vaccination of individuals over school age (about 18 years) should generally be recommended only in those situations in which unusual exposure to poliomyelitis might be anticipated, such as epidemics, entry into military service and travel to other countries.' "

Other general statements about Polio Vaccine also were contained in the October 1 Health Department memo to division directors and directors of full-time local health departments.

THE CLINICAL SIGNIFICANCE OF Cutaneous Xanthoma

Cutaneous Xanthoma may appear as an early symptom of an underlying disease of lipid metabolism.

The morphologic appearance of these xanthoma provides a clue as to the nature of the underlying disease state. However, the specific diagnosis and classification of cutaneous xanthoma is based, not upon morphology, but upon appropriate study of the serum lipid values.

By JULES ALTMAN, M.D. and COLEMAN MOPPER, M.D., DETROIT

Cutaneous xanthoma have long been recognized as clinical entities and descriptive terms such as xanthelasma and xanthoma tuberosum are familiar medical vocabulary.

Recent literature[1,2,3] has emphasized that cutaneous xanthoma may appear as the initial symptom of an underlying disease involving lipid metabolism. An awareness of the different morphologic varieties of xanthoma is of importance to the clinician since it may provide a clue as to the nature of the particular underlying disease state.

Four morphologic types of xanthoma have been described. These are:

1. *Xanthoma planum (xanthelasma)—flat yellow plaques, most commonly appearing on the eyelids, and more rarely elsewhere on the trunk and extremities.*
2. *Xanthoma tuberosum—nodular, flesh-pink to yellow-orange masses situated over extensor surfaces.*
3. *Xanthoma eruptivum—small, discrete yellow papules often with an erythematous halo, often occurring abruptly in crops, over the trunk and extremities.*
4. *Xanthoma disseminatum—a rare type of muco-cutaneous xanthoma appearing as discrete and coalescent red-yellow to brownish papules involving the flexural and intertriginous areas.*

The morphologic diagnosis of xanthoma is only of limited usefulness, however, since the relationship between the morphologic variety of xanthoma and the etiologic disease state is not always specific. For example, xanthoma tuberosum indicates the presence of a disease of lipid metabolism, but these lesions may appear as a symptom of a number of disorders including essential familial hypercholesterolemia, idiopathic hyperlipemia, and xanthomatous biliary cirrhosis.

* * *

THE PRESENTLY ACCEPTED criteria for the diagnosis and classification of xanthomatosis is based, not upon morphology, but upon studies of the serum lipid values. The classification of lipid diseases by serum lipid values was originally proposed by Thannhauser and Magendantz.[4] The increased availability and refinement of biochemical laboratory methods for serum lipids has added greatly to our understanding of xanthoma.

Cutaneous xanthomatosis may be divided into three major groups depending on the predominating serum lipid fractions.

1. *Hypercholesterolemic xanthoma—where the principal abnormality is an increased serum cholesterol. Hypercholesterolemic serum is clear in appearance.*
2. *Hyperlipemic xanthoma—where the principal abnormality is an increased serum neutral fat (triglyceride). Hyperlipemic serum is cloudy (milky) in appearance.*
3. *Normolipemic xanthoma—where the serum lipid values are normal. Normolipemic serum is clear in appearance.*

A current classification[5] of cutaneous xanthoma based on serum lipid values is listed in Table I.

It is obvious that laboratory studies of the serum lipid fractions are required for the proper evalua-

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TABLE I. CLASSIFICATION OF CUTANEOUS XANTHOMA

A. Hypercholesterolemic (Serum Clear)	B. Hyperlipemic (Serum Cloudy)	C. Normolipemic (Serum Clear)
1. Essential Familial Hypercholesterolemia	1. Idiopathic Hyperlipemia	1. Degenerative (a) Xanthelasma Palpebrarum (50% of cases) (b) Generalized Xanthelasma
2. Secondary to: (a) Myxedema (b) Biliary Cirrhosis (1) Primary (Hanot's) (2) Secondary to Intrahepatic bile duct obstruction (a) Toxic (b) Allergic (c) Infectious (d) Congenital (e) Inflammatory (f) Hemochromatosis (3) Secondary to Extrahepatic bile duct obstruction (a) Neoplastic (b) Inflammatory (c) Congenital (d) Stone	2. Secondary to: (a) Diabetic Acidosis (b) Nephrotic Syndrome (c) VonGierke's disease (d) Chronic Pancreatitis (e) Cobalt intoxication	2. Proliferative (a) Xanthoma with histiocytosis X (Hand-Schuller Christian Type) (b) Xanthoma Disseminatum (c) Juvenile Xanthogranuloma (d) Histiocytoma (e) Reticulohistiocytoma

tion of patients with xanthomatosis. It is important to remember that blood for such studies should be drawn with the patient fasting. Although the serum cholesterol value remains relatively unchanged after meals, the value for neutral fat is normally markedly increased postprandially (alimentary lipemia).

* * *

THE SIMPLEST PROCEDURE consists of gross inspection of patients' fasting serum. Patients with xanthoma and cloudy (milky) serum have elevated levels of neutral fat (over 600 mgm per cent) and may also have a concomitant, but less marked elevation of cholesterol and phospholipids. This constitutes hyperlipemia which may be of the idiopathic type or secondary to the diseases listed under hyperlipemia in Table I.

The early recognition and treatment of a disease such as idiopathic hyperlipemia is of particular importance because of the reported 30 per cent incidence of atheromatous cardiovascular complications. The disease usually responds well to treatment consisting of low animal fat diet with supplemental unsaturated fatty acid. It may be possible to lessen the cardiovascular complications of idiopathic hyperlipemia if treatment is instituted early and the serum lipid levels are controlled.

Patients with cutaneous xanthoma and clear serum will have either normal or elevated levels of cholesterol, cholesterol esters and phospholipids, but no marked increase in neutral fat. Hypercholesterolemic xanthoma may appear with essential familial hypercholesterolemia and more rarely with myxedema and biliary cirrhosis (Table I).

* * *

APPROXIMATELY 50 PER CENT OF patients with xanthelasma of the eyelids will have elevated serum cholesterol values, from 300 to 500 mgm per cent. Such patients may show coronary and cerebral atheromatous complications. These complications can be expected to be early and severe when the cholesterol value is above 600 mgm per cent and when xanthoma tuberosum and tendinosum are present as well. All patients with xanthelasma should have studies of serum lipid values in order to detect essential familial hypercholesterolemia.

Most patients with xanthomatosis may be properly diagnosed and classified by obtaining the fasting values for total serum lipids, total cholesterol, and a report as to the transparency of the serum (i.e., clear or cloudy). Additional information may be gained from the values for cholesterol esters, phospholipids and total fatty acids. These values can be used to calculate the serum triglycerides indirectly, although a more accurate direct determi-

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nation of triglycerides is also available. The interpretation of serum lipid values may at times be difficult and depends on some understanding of the particular biochemical method of lipid determination employed by the laboratory reporting the results.

Other investigative methods such as ultracentrifugation and lipoprotein electrophoresis have also been used to study the serum lipids of patients with xanthomatosis, but these procedures are expensive and not readily available and do not add materially to the clinical evaluation of such patients.

Patients with normolipemic xanthoma form a somewhat separate group since they have no apparent systemic upset of lipid metabolism. If we consider hypercholesterolemic and hyperlipemic xanthoma to be "metabolic" in origin, then normolipemic xanthoma may be considered "degenerative" and "proliferative" in origin.

* * *

NORMOLIPEMIC XANTHELASMA of the eyelids, the commonest type of cutaneous xanthoma, and a rare type of generalized xanthelasma[5] probably develop secondary to local degenerative influences in the skin. Anatomical peculiarities, such as the thinness of eyelid skin which lacks subcutaneous fat tissue, may tend to favor this localization of xanthelasma.

Xanthoma of the proliferative group include a number of rare disease entities which have as their basic feature, a proliferation of histiocytic cells. The entities included in this group of reactive histiocytic proliferation actually form a spectrum of related diseases which includes: Histiocytosis X (particularly the Hand-Schuller Christian type), Xanthoma disseminatum, juvenile xanthogranuloma and probably reticulohisticoytoma and histiocytoma as well.[6]

The cutaneous lesions of these diseases are not xanthoma in the same sense as xanthoma tuberosum. However, histiocytic cells retain a capacity to produce lipid substances and, thus, transform themselves into xanthoma cells. In this manner, lesions of proliferating histiocytes may accumulate lipid material and appear secondarily xanthomatous.

SUMMARY

The present classification and diagnosis of cutaneous xanthomatosis is based upon studies of serum lipid values rather than on the morphology of lesions.

Cutaneous xanthoma may appear as the initial symptom of an underlying disease involving lipid metabolism. Gross inspection of the fasting serum of patients with xanthoma to determine if it appears clear or cloudy (milky) plus appropriate laboratory studies of serum lipid values will usually permit proper etiologic diagnosis.

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COMING IN DECEMBER

Traumatic Deformities of the Nose

Dr. G. Jan Beekhuis, Professor and Chairman of the Department of Otolaryngology at Wayne State University College of Medicine, presents an excellent article in December with many illustrations on traumatic nose defects.

Epidemiology of Leukemia Mortality in Michigan

A definitive study on the epidemiology of leukemia mortality in Michigan over a ten-year period is presented by Dr. Donald C. Smith and his associates from Ann Arbor and is of interest to every physician.

Therapy for the Hemophilic Patient

Dr. John A. Penner presents a guide to therapy for the patient with hemophilia that will be useful to any physician who might see a hemophilic patient.
These and other papers will appear in the December issue.

With the detection of incipient difficulties in maturational development and psychologic adjustment of young children, the physician can perform a strategic, significant role in the prevention of subsequent educational or behavioral problems. Remedial programs should include the newer psycho-pharmacologic drugs. By their adjunctive use in the hyperkinetic or lethargic child with cerebral dysfunction, promising beneficial results have become apparent. Such preventive efforts in mental hygiene, especially focused on the pre-school child, are deserving of further investigation.

The Hyperkinetic Or Lethargic Child With Cerebral Dysfunction

BY
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The recent clamor of parents for the earlier achievement of learning capabilities in the elementary grades (as evidenced by the popularity of the "Why Johnny Can't Read or Do Arthmetic" books) is well apparent. Combined with this, the impact of the overcrowding of educational facilities with the consequent stress on teaching personnel, has highlighted the occurrence of deviant behavior and shortcomings of some young school children.

With the responsiveness of a sizeable segment of these children to definitive medical and psychologic therapy, a provocative challenge to pediatricians and child psychiatrists has to be met.

The use of stimulating drugs such as the amphetamines or methylphenidate has demonstrated increasing evidence of improved learning ability in many of these children.

The hyperkinetic or lethargic child with cerebral dysfunction presents a unique cluster or complex of behavioral disorders, which may reflect varying degrees of structural and/or functional changes in the brain. No other category of childhood ailments poses a more pressing need for the utmost degree of collaboration and teamwork of the disciplines concerned with behavior, learning, and emotion.

° ° °

THE PREVAILING KNOWLEDGE covering etiology, diagnostic criteria, together with the use of the newer psycho-pharmacologic drugs for the hyperkinetic impulse disorder herein described, affords a favorable milieu for implementing Eisenberg's refreshingly new approach towards a Preventive Psychiatry.[2]

At least the first two of the three levels of preventive effort could be regarded as applicable for a concrete contribution in mental hygiene. In *primary prevention* one could attempt to preclude, within limits, the development of fetal or newborn brain damage by fostering the optimum type of prenatal care, avoidance of potentially-noxious drugs during pregnancy and labor, and, in addition, high standards of premature, and infant care. At the next level of *secondary prevention*[3] early diagnosis can be achieved by the alertness of pediatricians and psychiatrists in recognizing the typical behavior patterns and psychologic test characteristics of the hyperkinetic or lethargic, under-achieving child with cerebral dysfunction. Adequate doses of the above-mentioned drugs, if effective, tend to shorten the duration of, or improve, deviant behavior. With improved learning ability, better school and social adjustment can be anticipated. In addition to medication, a combination of counseling with parents, and special educational measures makes for prevention of mental illness at the above-mentioned levels feasible.

° ° °

ALTHOUGH PARENTS MAY have experienced recurring distress and suffering over a period of years, extending from infancy throughout the run-about age of their hyperactive or lethargic child, they may regard their confrontation with the school situation as almost cataclysmic. Their perplexity with such a problem child can be appreciated in view of his seeming normality, both physical

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and mental. In part, they are reassured by the generally-accepted notion of the average robust youngster, with his excessive energy and activity, restlessness, and fidgetiness.

Early diagnosis and treatment is essential to the child's welfare as well as for that of his classmates, teacher, and family. The vicious circle that so often follows classroom failure—i.e., discouragement, clowning, defiance, disruptions of other studies, poor self-esteem, association with other socially rejected children, et cetera, may be prevented. The age span of hyperkinetic behavior disorders extends from the early preschool period through adolescence. Dr. Leon Eisenberg has recently stated that the condition "begins to remit as the child grows older, with final phasing out by adulthood."

* * *

A MORE ACCURATE ASSESSMENT and diagnosis can be ascertained if certain areas of inquiry are carefully explored, relating to the prenatal, perinatal periods, as well as growth and developmental patterns. The children's physician can learn to recognize the more subtle examples drawn from the extremes of the continuum of reproductive casualties proposed by Pasamanick.[4] Aside from the hazards of birth, the fetus is constantly exposed to toxins, infectious agents, and drugs.

Since the Thalidomide disasters many drugs commonly used as analgesics, antiemetics, and tranquilizers, have come under surveillance as potentially harmful. Cerebral dysfunction syndromes with hyperkinesis, perceptual handicaps, and/or lethargy are increasing in frequency as more partially damaged infants survive threatened abortion, maternal toxemia, prematurity, erythroblastosis, meningitis, et cetera; the degree of impairment of function is variable.

Early diagnosis is based on alertness to data drawn from six areas (A through F below):

(A) Complaints of either (1) academic performance below potential or (2) hyperkinetic, disruptive behavior or (3) both 1 and 2. Such children usually also have unpredictable dispositions and/or erratic performance, poor frustration tolerance; they are often forgetful, perseverative, easily overstimulated and scapegoated. Adults often refer to them as "brats."

(B) The health history usually discloses an event or series of events that could partially damage immature nervous tissue.

(C) Atypical development of sleep, speech, locomotion, object relationships, of the learning of skills and controls; unusual responses to pain, cold, and other sense modalities; atypical vegetative controls, et cetera.

(D) Behavioral peculiarities, such as stimulus boundness, driveness, confusion, memory lapses, perseverations, awkwardness, accident proneness, impulsivity.

(E) Psychological and psychiatric examinations reveal dyspraxias, thinking disturbances, poor Gestalt recognitions, excessive regression with affective stimulation, visual-motor impairment, inconsistent and fluctuating performance, and poor self esteem.

(F) Neurologic examination may disclose definite signs of neural impairment: paralysis, spasticity, athetosis. Other findings might include: gait disturbance, speech defects, poor graphesthesia, immature postural reflexes.

The child may not have symptoms in all or even many of these areas. Each child has his own cluster of findings. Certain general principles underlie many of the above signs. Defects in the ability to receive, hold, scan, and use information input may occur. These "mechanical" defects in "computing" are potentially productive of maladaptive behavior.

* * *

ONE CAN SOUNDLY recommend special classroom management and educational techniques, if a coherent syndrome emerges from a review of the data in the six areas mentioned above. The child may need psychotherapy. This decision should be based on a specific situation and must be individualized. He may need remedial education, or training in basic athletic, educational, and social skills.

During the school years, many such children have learning problems, particularly with reading and mathematics. If medication improves his attention controls, stabilizes his moods, reduces his impulsivity, the most important therapy may be sensibly directed to changing the environment. If the attitudes of those around him shift favorably, direct psychotherapy with the child may be unnecessary.

Experience of one of us (H.H.C.) at the Children's Center of Wayne County with over 100 cases indicates that 70 per cent of the children who had D's or E's in conduct, improved to C's or better while receiving dextroamphetamines or methylphenidate. The period of observation ranged from six months to four years, during which time this improvement was maintained.

Only about 15 per cent of the children have side



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Cooperative Project to Aid Medically Indigent Mothers

In an attempt to help reduce the incidence of prematurity, perinatal mortality, and various birth defects, a maternity and infant care program for medically indigent patients in Detroit has been planned by the Michigan Department of Health in cooperation with the Detroit City Health Department and with the advice of the Maternal Health Committees of the Wayne County and Michigan State Medical Societies.

Financed by a Children's Bureau grant through the Maternal and Child Health Division of the Michigan Department of Health, the program will serve the high-risk population in central Detroit.

Statistics there show the percentage of prematurity averages 14.8 compared to the state average of 7.6; the perinatal mortality rate averages 56.3 per thousand live births there compared to the state average of 31.4; and the neonatal mortality rate averages 26.6 there, compared to 17.8 for the state.

It is not surprising that studies indicate that more than one-third of these medically indigent obstetrical patients receive no prenatal care at all, points out the state department. Of those who do, such care is often limited to a single visit to the city obstetrical clinic during the last month of pregnancy. Infant care following childbirth is almost nonexistent. Studies indicate that the lack of good prenatal care is associated with prematurity, perinatal deaths, and a high rate of birth defects, including various forms of mental retardation.

Because Crittenton General, Woman's, and Detroit Memorial Hospitals are located in the areas with the highest risk population, and because they have been interested in service to the community, the maternity and infant care program is at present, focused in these three hospitals. These hospitals will provide a unified program of complete maternity care followed by a program of neonatal care for infants born to these medically indigent, high risk mothers.

The maternity care to be provided includes outpatient antepartum and postpartum care up to the end of the eighth week following delivery. The neonatal care includes pediatric supervision and care during the neonatal period, adequate nursery services, arrangements for referral of infants with special problems, and pediatric outpatient appraisal of the infant at 4-6 weeks of age. In addition, there will be social work services available both in the clinic and in the hospital; public health nursing services in the clinic, hospital, and home as needed; nutrition and dietary services; and a program of expectant parent education made available to as many mothers as possible.

In general, hospitalization for the patients will remain a responsibility of the Wayne County Department of Social Welfare and the Michigan Crippled Children Commission, but some project funds will be used to pay for selected high risk patients whom the above agencies cannot accept. It is expected that the program will care for about 1500 medically indigent patients per year at Detroit Memorial, about 1200 per year at Crittenton General, and about 600 per year at Woman's.

Also cooperating in the program are the Wayne County Department of Social Welfare, Michigan Crippled Children Commission, Wayne State University, and University of Michigan.

Hyperkinetic Child

(Continued)

effects of anorexia, sleeplessness, excessive irritability, sufficient to make the usefulness of the medication dubious.

Currently, methylphenidate is the drug of first choice for the school-age child who has not had convulsions; with it, insomnia or anorexia are less likely. It must be given morning and noon for best effects on school performance. For the average school child, the dose ranges from 2.5 to 5 mg. twice daily as above for three days; and then the dose may be gradually increased at intervals, until maximum benefit or undesirable side effects occur. This optimum dosage is usually maintained daily for from two to four years. If dextroamphetamine is given, the same pattern is employed, although the milligrams per dosage is one-half that used for methylphenidate.

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Doctors Explain Care Plans for Aged

Use Community Health Week for Newspaper Ads

An intensive educational program was conducted by physicians and their organizations to acquaint Michigan residents with the broad range of health care programs available to the elderly during Community Health Week, October 18-24.

"The medical profession took the lead in this educational effort because so many people are not aware that help does exist for those over 65 who need it in paying for health care," reported Oliver B. McGillicuddy, M.D., Lansing, MSMS President.

The campaign urged Michigan residents who wanted information about health care programs for the aged to ask his family doctor.

The intensive educational program features advertisements in Michigan newspapers, radio and television programs, M.D. speakers bureau, educational brochures and other communication materials and methods.

Many queries were received by the county medical societies and MSMS.

"We found that few patients know about the various aid programs available to them," reports Doctor McGillicuddy. "For example, almost $31 million in health care was provided Michigan residents over 65 through the Medical Aid to the Aged law alone during the last fiscal year—but few people know about this program."

MSMS members found help in answering questions from the new MSMS booklet, entitled "Governmental Health Care Assistance Programs in Michigan." The booklet should be saved as a reference handbook to enable the doctor to help refer all persons to the right county, state and federal agency and organization for medical-financial assistance, urged Doctor McGillicuddy.

NOTE: An article about the many Community Health Week projects carried out across the state will appear in the December issue of Michigan Medicine.

The "Silent Service"

Usually when nearly $31 million is spent on a relatively new project through a Michigan agency it creates quite a little ripple of publicity. Normally when over 26,000 people receive an average of over $1,100 apiece in services from the new program there is a bit of fanfare.

The publicity and fanfare have been missing from the Michigan Medical Aid to the Aged Program (established under the Kerr-Mills law) now in its fourth year here, which is guaranteeing medical and hospital care to all those people over 65 years of age who are not on welfare but who need help to pay hospital and medical bills. (Those on welfare have their bills paid under other governmental programs.)

Recent figures released by the Michigan Department of Social Welfare, which administers the program even though the recipients are not on relief, reveals that Michigan residents received $30.9 million in Medical Aid to the Aged—Kerr-Mills, during the 1963-64 fiscal year. The state agency reports that 26,479 beneficiaries received the more than $30 million—$28.4 million of which was paid to hospitals, $500,000 to nursing homes and $1.5 million to physicians.

Why no publicity on this obviously successful program? Try these three reasons on for size:

1. The U.S. Department of Health Education and Welfare is trying to sell Medicare. If people know the present program is meeting the need for hospital and medical care they won't favor a new Medicare program sponsored by an increased Social Security tax.
2. The Medicare program suffers by comparison with the Medical Aid to the Aged program. The latter offers complete coverage. The former offers only limited hospital care, no medical care. This knowledge won't create votes for Medicare supporters.
3. Medicare offers "something for nothing" to all the people under Social Security—whereas MAA discharges the responsibility of protecting everyone over 65 years of age who can't protect themselves. Thus Medicare is a bigger vote getter.

Conclusion: The government's propaganda machine turns out bushels of releases on Medicare, none on MAA.

Late News

Once again, these four colored pages carry late-breaking news as an added service of Michigan Medicine to the members. A late deadline permits Michigan Medicine to insert these four pages as the journal is being assembled.

Starr Leaves MMS For Bank Position

In his report to The MSMS Council, October 28, Michigan Medical Service President Sidney Adler, M.D., announced that "Frank O. Starr has resigned as Acting Executive Director to accept a position as Assistant Vice President, National Bank of Detroit, effective November 1."

Doctor Adler added that "Mr. Starr's resignation is a distinct loss to Michigan Medical Service and, I might add, to the medical profession of Michigan. Mr. Starr was a dedicated and knowledgeable servant of the voluntary prepayment system."

Flint to Host MSMS Maternal Welfare Meet

Four national authorities have been obtained already to speak at the fourth annual Maternal and Perinatal Welfare Conference in Flint, March 11-12, under the sponsorship of the MSMS Maternal Health Committee and the Clara Elizabeth Fund of Flint.

Coming for the conference, at the Pick-Durant Hotel, are Joseph Dancis, M.D., New York City; Robert E. L. Nesbitt, Jr., M.D., Syracuse; Edith L. Potter, M.D., Chicago, and John Rock, M.D., Brookline, Mass.

William W. Jack, M.D., Grand Rapids, Chairman of the MSMS Maternal Health Committee, reports that further details will be reported in future issues of Michigan Medicine.

MSMS President's Page Reprinted For AMPAC Use

October 21, 1964

"The cover of the October issue of Michigan Medicine with the flag motif is certainly a beautiful job, and of course, we very much appreciate the message by Doctor McGillicuddy on the President's Page.

"Incidentally, I wonder whether you could make available approximately 800 copies of the President's Page which we will distribute to our key membership list. Thank you."

Joe D. Miller,
Executive Director,
AMPAC,
Chicago.

(NOTE: Offset copies of the Page about "How Will You Feel the Morning of November 4th?" were provided).

MONROE—A series of classes for prospective mothers and fathers is being conducted in Monroe by the Monroe County Medical Society, and the local hospitals.



An educational display about Smoking and Health was shown by the Michigan Health Council for the first time at the annual convention, October 14-16 of the Michigan Nurses Association in Detroit. One of the speakers at the Nurses Convention was Oliver B. McGillicuddy, M.D., MSMS President.

Exhibit, Guidebook to Explain Smoking-Health Issue to Youths

Michigan students from the 5th through 12th grades now will have a much better opportunity to learn facts concerning smoking and its relationship to health and disease. A new 32-page Smoking and Health Guidebook is being distributed to school administrators, principals, school nurses, health educators, home economics and science teachers.

Elizabeth L. Wheeler, Dr. P.H., Director of Health Education, Central Michigan University and School Health Consultant to the Michigan Department of Health, served as editor of the guide. Other participants in the development and preparation of the smoking guide included representatives of the Michigan State Medical Society; Michigan Department of Health, Michigan Tuberculosis and Respiratory Disease Association; American Cancer Society; Michigan Cancer Foundation; Michigan Heart Association; American Cancer Society; Michigan Education Association; Detroit, Dearborn, Melvindale, Lincoln Park, Saginaw and Inkster Public Schools and Tuberculosis and Health Society of Wayne County.

Henry J. VandenBerg, Jr., M.D., Detroit, Chairman of the Cancer Control Committee of the Michigan State Medical Society, has been named Chairman and John A. Doherty, of East Lansing, Executive Secretary of the Michigan Health Council, has been named Secretary of the Michigan Council on Smoking and Health.

This new program will be supported by the voluntary health agencies in Michigan that are interested in the smoking problem, and the program will be coordinated by the Michigan Health Council. Interested physicians may obtain a free copy of the guide by writing to the Michigan Council on Smoking and Health, P.O. Box 431, East Lansing.

Counties Offer Polio Vaccine

Several county medical societies are conducting oral polio vaccine programs this fall.

Other county societies offered the service in their communities during the spring.

As in the spring, the physicians are receiving excellent cooperation from the pharmacists, nurses, medical assistants, schools, civic organizations and volunteers.

MHC Recruiting for Physical Therapists

Efforts to recruit more physical therapists are underway by the Michigan Health Council.

E. A. Irvin, M.D., Detroit, president of the Michigan Health Council, explains that one of the main activities of the new program will be to acquaint more Michigan high school and college students with the vast opportunities that await them in careers in rehabilitation, particularly in physical therapy.

During Community Health Week, October 18-24, the Health Council began distribution of a new rehabilitation careers kit. The kit informs high school and college counselors with the opportunities in the health field about the requirements, scholarships and loan funds available in Michigan in medicine, physical therapy, occupational therapy and many other careers in rehabilitation.

The Sister Elizabeth Kenny Foundation and the University of Michigan Department of Rehabilitation and Physical Medicine made special grants to the Health Council to develop a special Careers in Rehabilitation Program. The Michigan Tuberculosis and Respiratory Disease Association also has cooperated with the Council by printing the new Rehabilitation Careers Kit.

A free copy of the kit may be obtained by writing Michigan Health Council, P.O. Box 431, East Lansing.

A new MHC health careers exhibit will depict the role of the physical therapist in assisting the doctor in the rehabilitation of the patient. The Department of Physical Medicine and Rehabilitation of The University of Michigan is co-sponsoring the exhibit.

There also will be a series of television programs, news articles and rehabilitation career conferences and open houses. This aspect of the program will be co-sponsored by the Elizabeth Kenny Foundation, located in the Rehabilitation Institute, Detroit.

Doctor Irvin stated that one of the principal reasons why the recruitment program is being undertaken at this time is that The University of Michigan has doubled the size of the class that will be enrolled in Physical Therapy next fall and that Wayne State University will open its new Physical Therapy program to 35 students in the fall of 1965.

Michigan Medical Events

November 5—South Western Michigan Clinic Day, Battle Creek.

November 11-12—Michigan Academy of General Practice, Annual Fall Postgraduate Clinic, Sheraton-Cadillac Hotel, Detroit.

November 13-16—National Society for Crippled Children & Adults, Statler-Hilton Hotel, Detroit.

November 14-15—Michigan Allergy Society, Midwest Forum on Allergy, Henry Ford Aud., Detroit.

November 18—Conference on Coordinated Home Care for Hospital Administrators at School of Public Health, U-M, Ann Arbor.

December 2—Annual Symposium on Trauma, Wayne County Medical Society, Detroit.

December 3—American Academy of General Practice, Vascular Day, Bancroft Hotel, Saginaw.

December 16-18—Michigan State Health Conference on Epidemiology, Jack Tar Hotel, Lansing.

1965

February 22-26—Canadian-American Medical and Dental Ski Ass'n, Boyne Highland, Harbor Beach.

Galens Society 50 Years Old At U-M Reunion

The 50th anniversary of the Galens Honorary Medical Society was one of the highlights at the annual University of Michigan Medical Center Alumni Society conference October 14-15-17.

More than 100 present and former members of the Galens Society, a student service group at the U-M Medical School, gathered for a banquet which honored A. C. Furstenberg, M.D., Dean Emeritus. Doctor Furstenberg was one of the founders and serves as honorary prefect.

The Medical Center Alumni Conference drew 358 doctors, wives and nurses for scientific meetings, reunion meetings, etc. Eight "5-year" classes held special banquets at various Ann Arbor restaurants and two of the reunioning classes preceded their social events with scientific programs at the Medical Center.

An all-conference banquet and dance was held on October 16 following a full day of scientific sessions. The reunion closed with a picnic prior to the Michigan-Purdue football game.

In Brief:

DOWAGIAC—The Cass County Medical Society has gone on record supporting a Cass County Community College proposal. In releasing this action to the press, the Medical Society pointed out that "its members have an exceptional interest in the education of Cass County youths, and that many of them have or are serving on boards of education."

* * *

ANN ARBOR—The University of Michigan has received a grant of more than $5 million from the U. S. Public Health Service for the construction of a new dental building. The $5,034,265 grant and the new building will enable U-M to increase its dental school enrollment from 350 to 600.

NEWSPAPERS HELP PEOPLE TO RECOGNIZE NEW SYMBOL

Michigan newspapers are cooperating in the Michigan State Medical Society effort to help everyone learn to identify the new AMA emergency medical identification symbol.

Photographs of the symbol with a news article were sent to the newspapers by MSMS public relations staff.

As a result of the newspaper articles, several county medical societies requested MSMS to send them additional supplies of the free Emergency Medical Identification Cards. The news article contained an invitation from Oliver B. McGillicuddy, M.D., MSMS President, "that persons who need the card should ask their physician for such a card because it will help protect life."

Copies of the card with an order blank were sent to every physician in September and small supplies of the card were ordered by many members. Any MSMS member who wishes additional cards for distribution to patients who should carry such a card may secure them from MSMS, Box 152, East Lansing.

BATTLE CREEK—A series of continuing courses in psychiatry for non-psychiatric physicians is underway in Battle Creek this fall. The courses were initiated in 1961 by the Michigan Society of Neurology and Psychiatry and the Michigan District Branch of the American Psychiatric Association in Kalamazoo and Saginaw. The series since has expanded to include Grand Rapids, Flint and Jackson—and now Battle Creek. The program has the approval of the Calhoun County Medical Society, which has urged physicians to attend.

GRAND RAPIDS—At the Michigan Society of Gerontology annual meeting here, V. K. Volk, M.D., Saginaw, was installed to serve as president for the coming year. Doctor Volk outlined plans to pinpoint local needs and services for older persons as a new dimension of the Society's program.



Advisory Council Urges Mental Health Be Separate Department

The Michigan Mental Health Advisory Council has officially recommended that the Department of Mental Health be retained as one of the 20 principal departments under the provisions of the new state constitution. Peter A. Martin, M.D., Detroit, is chairman of the Council.

In a thirty-two page outline of its recommendations the Advisory Council concludes: "To include the Department of Mental Health in any other department in the state government would be contrary to the development of prevention, detection and treatment of mental illness among the citizens of the State of Michigan.

"Basic to the continued success of the Mental Health Program in the State of Michigan is that the Department of Mental Health be retained and administered as a separate and autonomous department in the reorganization of our state government."

The Council also recommended that "It would be appropriate to include under the Department of Mental Health the functions of the State Board of Alcoholism for the reason that alcoholism is known primarily as a behavioral problem."

50-Year Men Write: '14 Grad Comments On Special Event

Warm, friendly letters have been received at the MSMS Headquarters from many of the physicians who were honored by the 1964 MSMS House of Delegates for 50 years of medical service.

Typical of the notes from the men who were not able to attend is one from B. Hjalmar Larson, M.D., of Detroit. Following are a few excerpts from his letter:

"I regret very much my absence at the celebration, which I know will be a great occasion for us, of the ancients, survivors of the class of 1914. However, I have made up my personal loss by spending four weeks in my native Sweden with friends, relatives, and in a very beautiful and progressive country.

"Please give my kindest regards to the celebrating alumni, and tell them that we, descendents of the fierce Vikings of old, are at heart a sentimental crowd who still listen to the murmurings of the pines, to the foot of which our nest was attached."

Over 3,000 Kits Of Smoking-Health Brochures Mailed

More than 3,000 packages of educational materials about smoking and health have been mailed to Michigan physicians by MSMS Cancer Control Committee and the Michigan Cancer Coordinating Committee.

An order blank for such waiting room material was sent to every physician and dentist in July and orders now have reached 3,075.

Any doctor, who did not return the order blank, may obtain the educational materials by writing to MCCC, Box 152, East Lansing.

ROCHESTER—Among the sponsoring groups for the Oakland Citizens League Political Forum at Oakland University October 21 was the Oakland County Medical Society. Candidates for top county, state and federal offices presented their views.

Opportunities in Occupational Medicine

By the Occupational Health Committee, MSMS

Keeping the third of our population that works for a living healthy and on the job involves all segments of the medical profession. It is of particular concern to the full or part-time industrial physician who assumes responsibility for a particular group of employees.

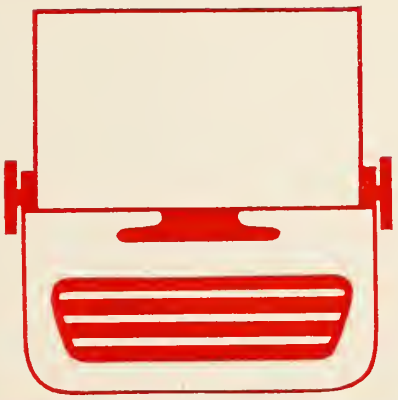
The variety of talents required to accomplish this task presents a real challenge to the physician and affords an opportunity for an interesting and rewarding career.

The clinical problems faced by the plant physician span the spectrum of human illness and injury from the common and the trivial to the exotic and the serious. His responsibilities range from the prevention of illness and injury to treatment and rehabilitation when disability arises out of employment. For the physician who enjoys the variety of general practice, this diversity is sure to be appealing.

Because of his relationship with the employees and with management, the physician is able to practice preventive medicine of highest quality. In-plant hazards may be removed. Employees may be placed in jobs for which they are physically and mentally suited. Periodic examinations and health counselling can direct the employee to outside medical care before illness becomes disabling.

The advantages in industrial practice are beyond the professional opportunities afforded. Work can be scheduled so that there is opportunity to enjoy family and friends, to engage in hobbies and participate in community activities. While the gross salary income may seem small, the net income with fringe benefits, including retirement plans, stock investment and savings plans, annual bonuses and the like make the total comparable to that earned in private practice.

Parttime or fulltime, the practice of occupational medicine has many attractions which should be weighed carefully by the physician and his family.



EDITORIAL VIEWS

Some Factors Influencing The Therapeutic Value Of A Medicinal Agent

By Martin Barr, Ph.D.,
Dean of Pharmacy,
Wayne State University

Physicians, pharmacists, and indeed, all members of the public health team continually strive to provide optimum patient care for the sick. One important aspect of this objective is to insure that patients are administered the most efficacious drug products with a known reliability of pharmacological action. The absorption and ultimate therapeutic activity of a given drug product are governed by many factors other than the general pharmacological properties of the active ingredient, factors which are determined and controlled by pharmaceutical and medical scientists in the research, development, and production stages of the overall manufacturing process.

In this editorial, an attempt will be made to illustrate a few of the many physico-chemical and formulation factors which can influence the absorption, and therefore, the therapeutic activity of a medicinal agent.

Lipoid Solubility and Dissociation Constant—It is known that the gastrointestinal tract behaves as a lipidlike barrier to most drugs and that lipoid-soluble substances are absorbed through the tract

by the process of passive diffusion, whereas lipoid-insoluble agents usually do so with greater difficulty. Most drugs are weak acids or bases and they exist in solution partly in ionized form, depending on their dissociation constant and the pH of the solution. The lipoid-soluble form is the unionized form and hence, the form of the drug which is mainly absorbed through the gastrointestinal tract. Therefore, the dissociation constant of a drug, its lipid solubility, and in addition, its partition coefficient, influence its absorption characteristics.

One method by which the degree of dissociation of a drug and therefore the concentration of its lipoid-soluble undissociated form may be altered is by a modification in environmental pH. By the inclusion of basic substances such as sodium bicarbonate, it is possible to increase the absorption of drugs which are weak bases and decrease the absorption of those which are weak acids. Another method for doing this is by the preparation of slight modifications in the chemical structure of a drug. Thus, propionyl erythromycin ester lauryl sulfate is better absorbed than the weak base erythromycin, and methylated heparin is better absorbed at pH's 5, 6, and 7 than the weak acid heparin which is not absorbed above pH 4.

Tablet Disintegration Rate—Once a tablet is swallowed, it must first disintegrate in order to make its active ingredient available for absorption through the gastrointestinal tract. The U.S.P. XVI tablet disintegration test requires that a tablet completely disintegrate within one hour in the test procedure. What about tablets which disintegrate in times less than one hour? Is this not a variable influencing absorption?

Dissolution Rate—Once a tablet disintegrates, the granules which make up the tablet must disperse and this is then followed by dissolution of the drug particles before it is available for gastrointestinal absorption. Dissolution takes time and frequently is the rate-limiting step in the absorption process. There are many factors which influence the dissolution rate. One is the *particle size* of the drug. Some drugs dissolve very slowly in the gastrointestinal fluids and it becomes necessary to reduce particle size appreciably in order to increase surface area which may result in an increase in dissolution rate.

One outstanding example of this is the antifungal antibiotic griseofulvin. By using 0.5 Gm. of finely micronized drug, it has been possible to obtain the same blood levels as those following administration of 1.0 Gm. of a larger particle-size drug.

Another factor influencing the dissolution rate of a drug is its *solubility in the diffusion layer.* The rate may be increased by increasing the solubility of the drug in this layer by modifying the pH. This may be done by the use of basic substances such as sodium bicarbonate in the formulation or by the use of a highly water-soluble salt of a weak acid instead of the weak acid itself.

Crystal Form—Another factor influencing the absorption of some drugs is the crystal form of the drug. One of the most important examples of this is the antibiotic chloramphenicol. Therapeutic effectiveness of chloramphenicol palmitate is materially influenced by crystal form with amorphous drug being hydrolyzed in the intestinal tract most rapidly to yield available chloramphenicol. The specifications in the U.S.P. XVI do not distinguish between the crystal forms of chloramphenicol and thus, the reliability of the manufacturer in preparing a biologically active product becomes all important.

Drug Stability in Gastrointestinal Fluids—Drugs must remain in a stable form in the gastrointestinal tract in order to permit absorption of active compounds. By the adjustment of particle size and by other means, a drug which may deteriorate in the gastrointestinal fluids may be kept stable for the time necessary to permit its absorption.

Fillers—A tablet is composed of many ingredients other than the active drug. Many of these agents are capable of complexing with the active ingredient rendering it inactive in the gastrointestinal fluids. They may also increase or decrease the absorption of the active ingredient by various processes. Upon chemical assay, therefore, a product may show 100% content of active ingredient, but its absorption and therapeutic activity may vary considerably. For example, complexes formed between various di- and trivalent cations

and tetracycline reduce the absorption of the antibiotic. Certain surfactants are known to enhance the absorption of vitamin B_{12}, whereas others do not produce this effect.

Tablet Formulation Factors—The absorption of many drugs can be affected by various tablet formulation and processing factors. Some of these influencing factors are the type and concentration of excipient, the physical state of the drug, and tablet compression pressures. There are several examples in the literature showing the influence of these factors on the absorption of tolbutamide, penicillin, spironolactone and steroids from tablets.

In this relatively short message, it has only been possible to illustrate a few of the many physico-chemical and formulation factors which may influence the absorption and therapeutic activity of a drug. Tablet dosage forms have been referred to, but such factors alter the absorption and therapeutic activity of drugs in all types of dosage forms. From the few examples presented, it is clear that the therapeutic activity and efficacy of a medicinal product does not depend solely upon the qualitative and quantitative content of its active ingredient and that the activity of a drug can only be substantiated by well-controlled clinical investigation.

Those who believe that all generic name drugs are equivalent in therapeutic activity just because they assay within acceptable limits for the active ingredient should read medical reports on clinically unreliable or inactive brands of prednisolone tablets, thyroid tablets, and tolbutamide tablets to refer to just a few.

There is now no provision for completely defining therapeutic value by compendia nor generic description alone.

Welcome, New Members!

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MSMS Centennial Series: 1947, 1948

First Rural Health Conference Sponsored

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

—1947—

If you look in this issue and turn to the page "Officers of the Society" you will find the name of "William A. Hyland, M.D., Grand Rapids, Treasurer." Before his election to the office of President he was active in the Society and he still continues to play an active role until this year—1964.

Truly, he is one of the stalwarts of the Society.

Following are highlights of his year:

The first Annual Postgraduate Clinical Conference, featuring an all-Michigan program, was held in Detroit, March 12-14. The Conference was sponsored by the MSMS in cooperation with the Wayne County Medical Society, the University of Michigan Medical School, the Wayne University College of Medicine, and the Michigan Foundation for Medical and Health Education.

A "Committee on Awards" was named to formulate procedures and recommend policies which would permit the MSMS to properly honor those lay organizations and lay personages who, in the opinion of the Society, have contributed services of outstanding worth in the cause of health for the people of Michigan.

* * *

THE FIRST STATEWIDE Rural Health Conference was held at Michigan State College September 18-19, under the sponsorship of the Michigan State Medical Society with the cooperation of 25 other state organizations interested in rural health. The purpose of the conference was to explore the needs and problems of health in rural areas.

The Annual Session was held in Grand Rapids on September 23-26 with 2,110 registered. The House of Delegates authorized The Council to levy an assessment of $25 per member for the continuation of the Educational Fund. The delegates also created two new sections—the Section on Public Health and Preventive Medicine and the Section on Nervous and Mental Disorders.

The 6th Annual TB Speaking Project sponsored by the Woman's Auxiliary continued to improve over previous years. This year, 60 schools from 40 counties sent in scripts for state judging. Last year 52 schools from 32 counties participated.

* * *

RHEUMATIC FEVER Diagnostic Centers have been established by the MSMS in ten areas covering the entire State. This unique program of aid to the doctor of medicine in diagnosing the number one killer of children was started by MSMS in cooperation with the Michigan Society for Crippled Children and Disabled Adults and Michigan Crippled Children Commission.

MSMS appointed a committee to study the medical and hospital facilities of Jackson Prison, along with representatives from the Michigan Hospital Association, and the Michigan Department of Health.

"Fifty-Year Pins" were presented to 99 members of the State Society who have practiced 50 years or longer.

The following bills were passed by the Michigan Legislature in 1947:

1. An act to implement the provisions of the Federal Hospital Survey and Construction Act, with a director appointed by the Governor.
2. A law to license and regulate vivisection.
3. A law to require immunization against diphtheria, whooping cough, and smallpox as a condition precedent to entrance to school.

The Council adopted the resolution that young physicians whose training was interrupted by military service are eligible for Associate Membership.

—1948—

It doesn't seem possible it was 14 years since "Pat" (P. L. Ledwidge, M.D.), as we lovingly called him, left us. I knew Pat all his medical life. He was beloved by his patients, and his confreres admired him as a gentleman and an excellent clinician. Besides this, he was one of the hardest workers for the



The Author
WILLIAM J.
STAPLETON, JR., M.D.
MSMS Historian

advancement of medicine in our Society. I would like to list a few of his activities before he became President. He served on The Council, was a Delegate for years, worked on the Michigan Handbook several times, was on the Advisory Committee to Government Agencies, Speaker of the House of Delegates, and finally, MSMS President. As you look over this resume of his year as President, you will find it was a very busy one.

* * *

HIGHLIGHTS OF THE ANNUAL Session of The Council were:

1. "Michigan's Foremost Family Physician Award" was created.
2. Dues of Military Members of MSMS in active service were remitted for the year 1948.
3. Dissolution of Trusteeship between MSMS and William A. Hyland which in 1940 closed out medical legal activities of the MSMS, was approved.
4. Immunization Month (February) endorsed.
5. The Council requested the Foundation to consider ways and means of raising, establishing, and administering a student loan fund to encourage young physicians to locate in rural areas.

The Council in September recommended to the Committee on Constitution and Bylaws that it create a Committee on Diabetes as part of the MSMS Committee on Preventive Medicine.

The Executive Committee in August approved the appointment of an MSMS Committee to meet with the representatives of the American Heart Association; it also approved the formation of a Michigan Heart Association with the hope that it may become an affiliate of the AHA.

* * *

"LUCKY JUNIOR," a new MSMS motion picture, was distributed to all Michigan theaters during September and October.

The Woman's Auxiliary completed a public relations brochure for officers and committee chairmen of all county auxiliaries and the State Auxiliary. The brochure outlined various projects which the Woman's Auxiliary is interested in carrying through, such as the promotion of Health Month, Immunization Month, the Nurse Recruitment program, loan funds for Medical Students, Medical Associates, and the Blue Cross-Blue Shield Community Enrollment Plan.

The Kellogg Foundation was given the Distinguished Health Service Award by the MSMS in March at the Second Annual Michigan Postgraduate Clinical Institute. Don E. Johnson, of Flint, a patron of education in cancer control, was presented with the health service award of the MSMS in Flint at the annual meeting of the Genesee County Medical Society.

* * *

DURING APRIL, a membership campaign was carried on in each of the 55 county medical societies. A total of 260 new members were certified.

A project to establish a Beaumont Memorial Shrine on Mackinac Island was considered. Tentative plans were that the Early House be rebuilt in its original form.

At its September Meeting, the House of Delegates adopted the following resolutions:

1. Creation of a Committee on Geriatrics.
2. Creation of Medical Library Service.
3. Formulation of the National Agency for Voluntary Health Plans.
4. Special Assessment ($25) for 1949.
5. Creation of 17th and 18th Councilor Districts.



Wm. A. Hyland, M.D.
MSMS President, 1946-47



P. L. Ledwidge, M.D.
MSMS President, 1947-48

Michigan Authors

S. H. Schuman, M.D., Ann Arbor; **C. P. Anderson, M.D.** and **J. T. Oliver,** Detroit, "Epidemiology of Successive Heat Waves in Michigan", *Journal American Medical Association,* September 7, 1964, Vol. 189, No. 10.

D. R. Korst, M.D., Ann Arbor, (Coauthor) "Multiple Myeloma," *Journal American Medical Association,* September 7, 1964, Vol. 189, No. 10.

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Martin J. Urist, M.D., South Haven, "Vertical Muscle Paresis with Secondary Vertical Deviations" in two parts. *American Journal of Ophthalmology,* Part I, May, 1964, Part II, June, 1964.

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Centers Listed for Yellow Fever Vaccination

With the increase in foreign travel, Michigan physicians must advise patients more often about various vaccinations. The following article was prepared for MICHIGAN MEDICINE, with special information about yellow fever vaccination, by George H. Agate, M.D., Director, Division of Epidemiology, Michigan Department of Health:

"For those going abroad, a valid International Vaccination Certificate against smallpox is a basic necessity. After having received the vaccination, and if it is a primary, after the reading of it, it is necessary that the individual take the signed certificate to the local health department to have a validating stamp placed on it. Such validation may be obtained by mailing certificate to the Michigan Department of Health, Division of Epidemiology, 3500 N. Logan Street, Lansing.

"Only smallpox and cholera require a validating stamp. Cholera, plague, typhoid and yellow fever may be required in some parts of the world.

"The physician, in addition, may advise that typhoid fever, poliomyelitis, diphtheria, and tetanus protection be brought up to date. He can procure any of these vaccines through normal drug channels except yellow fever vaccine, which is given only in designated centers. This is because yellow fever vaccine is extremely fragile. It must be handled very carefully, kept frozen and thawed only for immediate use. If only one person receives the vaccine at a center the cost is usually higher per person than if several receive it.

"The centers in Michigan at which yellow fever vaccination may be procured are as follows:

Ann Arbor	University Hospital, University of Michigan, 1405 East Ann Street Tel.: 764-8181, Pediatrics Clinic, ext. 7101	Clinic hours Thursday 10 a.m. by appointment only Fee: Yes
Detroit	U. S. Public Health Service Hospital, Windmill Pointe. Tel.: VAlley 2-9300	Wednesday 10 a.m. Fee: No
Detroit	Henry Ford Hospital, Preventive Medicine Clinic, 2799 West Grand Blvd. Tel.: TRinity 5-2900, ext. 316, 317, 318	Wednesday 2 p.m. By appointment Fee: Yes
Detroit	Perkin Clinical Laboratory, 773 Fisher Bldg. Tel.: TRinity 5-2485	Mon., Tues., Thurs., Fri., 9 a.m.-5 p.m. Wed. & Sat.,9 a.m.-12 noon Fee: Yes
Midland	Midland City-County Health Dept., Courthouse Annex, 301 Main St. Tel.: 5-7781	Thursday 10 a.m. By appointment Fee: Yes
Traverse City	Thirlby Clinic, 116 Cass Street. Tel.: 946-8850	Appointment only. Advance notice of one week necessary at this center Fee: Yes

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PRO-BANTHĪNE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthīne (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] ". . . few, if any, have seemed to offer a distinct improvement, . . ."

Early investigations showed that Pro-Banthīne (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthīne] and propantheline [Pro-Banthīne].

The name Pro-Banthīne (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

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Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice –1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

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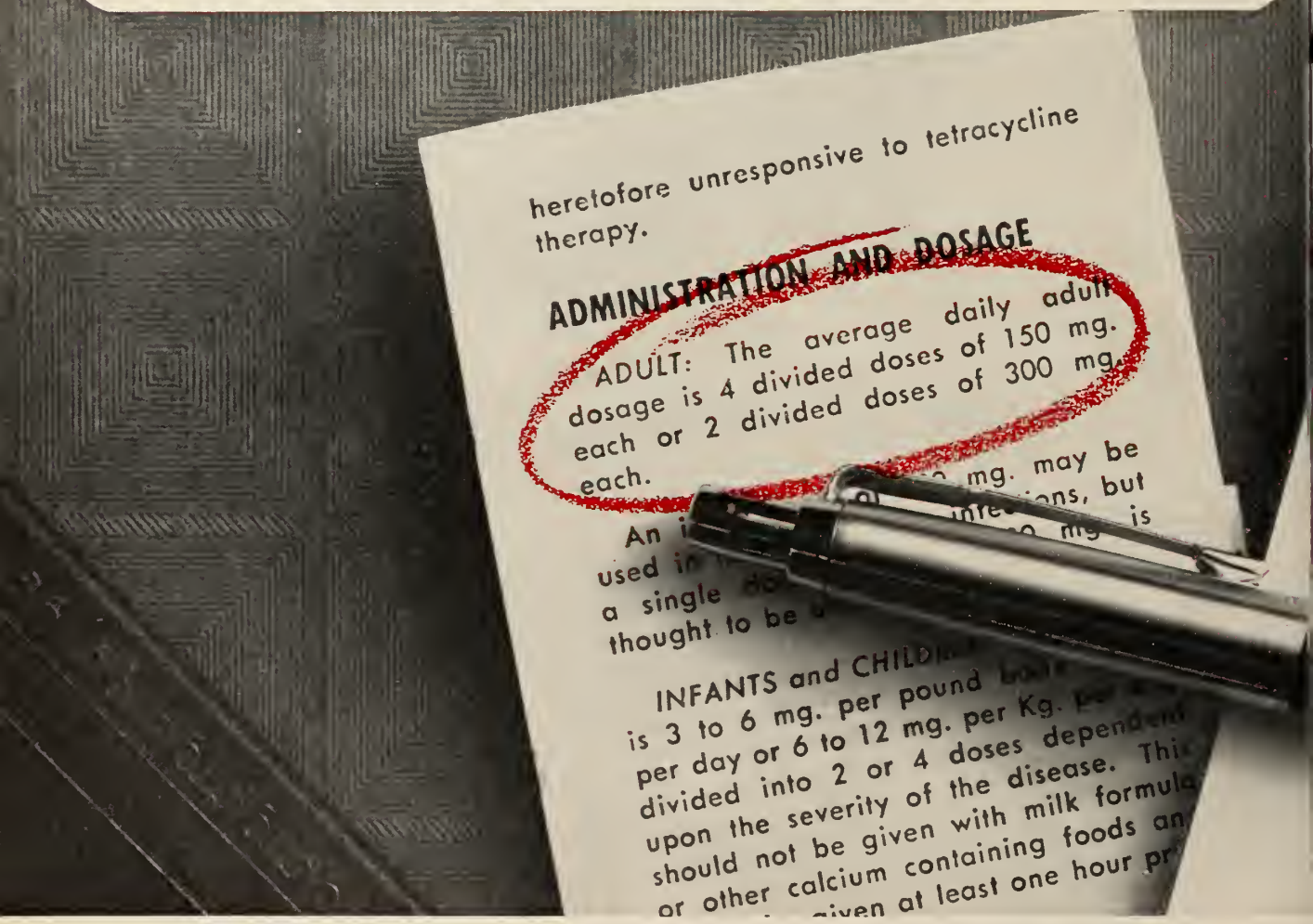
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extra convenience for the patient

...especially for the 34 to 62 patients out of a hundred who "skip" doses[1,2,3,4]



Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Side Effects typical of tetracyclines which may occur: glossitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood.

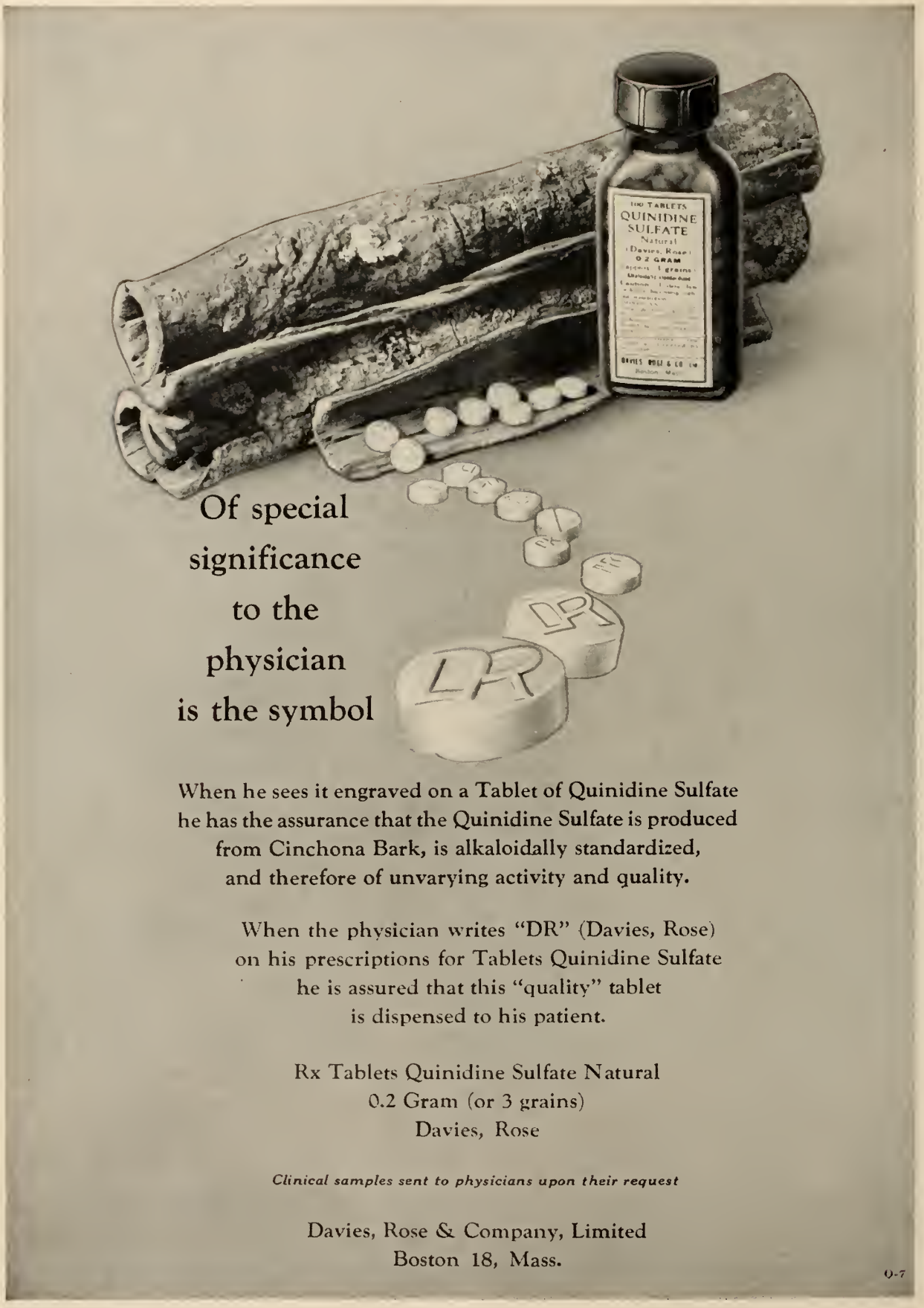
Capsules, 150 mg. and 75 mg. of demethylchlortetracycline HCl.

Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d.

References: 1. Schwartz, D.; Wang, M.; Zeitz, L., and Goss, M.: Medication Errors Made by Elderly, Chronically Ill Patients. *Amer. J. Public Health* 52:2018 (Dec.) 1962. 2. Dixon, W.; Stradling, P., and Wootton, I.: Outpatient P.A.S. Therapy. *Lancet* 11:871 (Nov. 2) 1957. 3. Curtis, E.: Medication Errors Made by Patients. *Nurs. Outlook* 9:290 (May) 1961. 4. Mohler, D.; Wallin, D., and Dreyfus, E.: Studies in the Home Treatment of Streptococcal Disease. *New Engl. J. Med.* 252:1116 (June 30) 1955.

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OUR STATE SOCIETY

18 PG Programs Slated In State by MSMS

The Postgraduate Education Committee of MSMS, with the cooperation of the University of Michigan and Wayne State University Schools of Medicine and the State Department of Health, is offering a series of educational programs again this fall.

Educators from the medical schools will visit the following cities during November: Grayling, November 12; Jackson, November 17; Midland, November 12; Petoskey, November 12; Traverse City, November 10.

The fall series began at Battle Creek on October 6. Other communities with PG lectures during October were Alpena, Lansing, Muskegon, and Niles in the Lower Peninsula and Calumet, Escanaba, Iron Mountain, Ironwood, Manistique, Marquette, and Sault Ste. Marie in the Upper Peninsula.

A program folder listing all 18 programs was mailed every MSMS member.

Physicians wishing more information about speakers, please write to the Michigan State Medical Society, Box 152, East Lansing; Attention: MSMS Postgraduate Education Committee.

AMA Lauds Society's Emergency Identification Efforts

Congratulations on your Emergency Medical Identification Program and the startling cover on the September issue of MICHIGAN MEDICINE.

We appreciate your efforts to promote what is rapidly becoming the universal symbol and we wish you every good fortune in the development of the statewide Program described in this issue.

Sincerely yours,
DONALD A. DUKELOW, M.D.
Assistant Director
Environment Medicine
American Medical Association

"Medical Care in Kalamazoo" Survey Available from MSMS

A limited number of copies of the "Study of Medical Care in Kalamazoo" are available for MSMS members interested in the possible evaluation of medical care in their own communities.

Completed in 1963, the Kalamazoo project was primarily a study of attitudes and was financed by a $20,000 grant from the Kalamazoo Foundation. The survey was executed by the Public Services Research Institute of Stamford, Connecticut.

Copies of the report have been circulated to MSMS officers and The Council and Delegates.

To obtain a copy, write to MSMS, 120 West Saginaw, East Lansing.

AMA Clinical Convention Set for Nov. 29-Dec. 2

Michigan physicians who attend the annual AMA Clinical Conference in Miami Beach, November 29-December 2, will find a program attuned to the current needs and interests of the practicing physician.

Immunization, depression, cardiac arrhythmias, vascular occlusive diseases, emphysema, iatrogenic diseases, and hypertension are only a few of the major areas to be explored during the four-day meeting.

More than 300 physicians will participate in a full program of lectures, exhibits, motion pictures, color television, fireside conferences and breakfast roundtables.



U. S. Congressman Gerald R. Ford, Jr., right, of Grand Rapids, was the Biddle Lecturer at the MSMS Annual State Society Dinner Dance. Shown studying the dinner program are Wm. A. Hyland, M.D., left, Grand Rapids, MSMS treasurer, and Oliver B. McGillicuddy, M.D., standing, center, Lansing, who was installed president at that event.



Here are seven MSMS Past Presidents who got together at the 1964 Annual Session in Detroit for their annual luncheon meeting. Host then, and now a member of the Past Presidents group, was Orlen J. Johnson, M.D., third from right, of Bay City. Left to right, the men are Otto K. Engelke, M.D., Ann Arbor; G. B. Saltonstall, M.D., Charlevoix; Otto O. Beck, M.D., Birmingham, Leroy W. Hull, M.D., Brighton; Doctor Johnson; H. H. Cummings, M.D., Ann Arbor, and Henry Cook, M.D., Flint.

AMA-ERF Loan Program Aids 465 in Michigan

During the first 28 months of operation, through June 30, 1964, the AMA-ERF Loan Program has provided loans to 465 young men and women in medical training in Michigan.

The AMA-ERF office further reports that the total principal of the 465 loans amounts to $540,200.

Loan activity across the nation has stepped up during the past six months and that trend is true also in Michigan with 115 loans during the first six months of 1964.

A 28-month report by Lyman J. Smith, director of the AMA medical education loan guarantee program, also states:

"From the beginning of the AMA-ERF Loan Program in March 1962 through June 30, 1964, a total of 15,289 loans had been made, with a combined principal value of $17,309,350. These loans were received by 10,398 individuals, 1,917 of whom were new borrowers in 1964. The total value of these loans, including principal and estimated interest, was $21,509,831. With each $1.00 in the Loan Guarantee Fund securing $12.50 worth of loans, $1,720,786, or 78 per cent of the $2,224,383 in the Guarantee Fund, had been committed.

"By June 30, there were 488 borrowers who had completed their medical training and were repaying their loans. An additional 139 had paid their loans in full.

"It is estimated that by 1970 the Loan Program will be self-sustaining—new loans will be offset by repayments, making additional contributions to the Guarantee Fund unnecessary. The income earned by the Fund should be sufficient at that point to cover defaulted loans.

"The Guarantee Fund requirement at that time should be in the neighborhood of $6 million—or approximately $3.7 million more than the Fund now contains. It is desirable, however, to achieve the $6 million total as early as possible to assure that funds will continue to be readily available and that no qualified applicant need ever be turned away because of lack of money in the Program.

"The response from physicians and private industry to the challenge of building the Guarantee Fund continues to be forthright and generous."

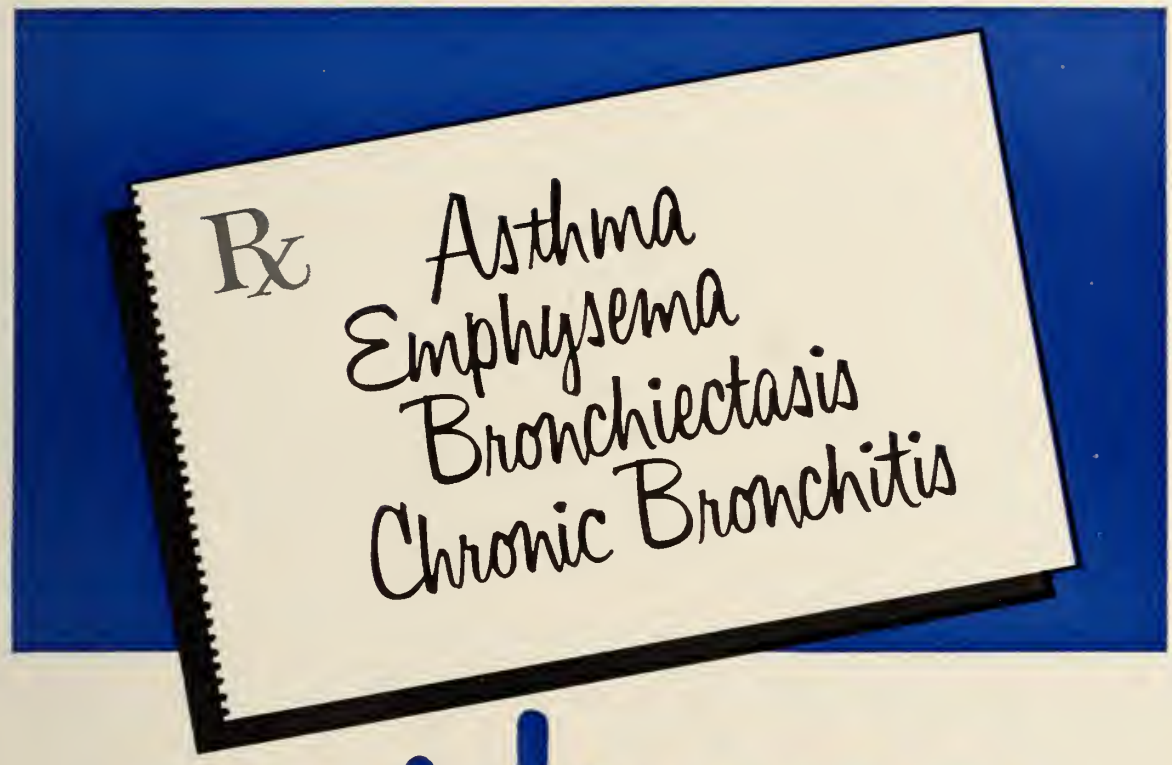
Readers Write

As an Associate Member of MSMS and the Wayne County Medical Society, let me tell you that I enjoy the Late News from the Michigan State Medical Society.

A. H. Naylor, M.D.
Milford, Michigan

I have just finished reading the September issue of the Journal of Michigan State Medical Society. I like its new format.

Sincerely,
Edgar C. Long, M.D.
Monroe, Michigan



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Each tablet contains Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 22 mg. (Warning: may be habit-forming), Potassium Iodide 195 mg. Dosage: One tablet, 3 or 4 times a day. Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, and very long use may cause goiter. Iodide contraindications: tuberculosis, pregnancy. Issued in 100's, 1000's.

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Abstract of MSMS Council Action

Meetings of September 20 and 24, 1964

PROGRESS REPORT ON MICHIGAN HEALTH FAIR

Plans of the Health Fair Finance Committee were received and The Council requested the Committee to complete its solicitation drive in time for report to The Council at its December meeting, when The Council will make a decision regarding continuation of plans for the Michigan Health Fair. The Health Fair Finance Committee expressed optimism that it would be able to raise the necessary funds to implement the Michigan Health Fair.

CONCEPT OF PUBLIC HEALTH

In lieu of the report of the Ad Hoc Committee to Study AMA Concept of Public Health, The Council adopted the following: "That the MSMS Delegates to the AMA, if in their opinion it is desirable, request AMA to include in the 1962 AMA Concept of Public Health the interpretive paragraphs of the AMA Board of Trustees expressed to the 1964 AMA House of Delegates." This action was reported to the MSMS House of Delegates in the verbal report of the Council Chairman.

AREA-WIDE HOSPITAL PLANNING

The Council received a report of a meeting with representatives of the Michigan Hospital Association regarding MHA's plan for a voluntary program of area-wide hospital planning. This report and any actions taken by the House of Delegates on this matter were referred to The Council's Hospital Relations Committee for study and report at the next meeting of The Council.

REPORT OF MICHIGAN MEDICAL SERVICE

MMS President Adler presented a supplemental report re the motor negotiations and the New York State Department of Health Medical Audit.

CORRESPONDENCE RE ADMINISTRATION OF BLUE CROSS ANESTHESIA BENEFITS

Information from the President of Michigan Hospital Service regarding Blue Cross anesthesia benefits was referred to the Hospital Relations Committee, which is already acting on this matter.

REPORT OF MICHIGAN HEALTH COMMISSIONER

A. E. Heustis, M.D., reported on the Health Department's 1965-66 budget request and anticipated state legislation.

DIABETES DETECTION PROGRAM AGREEMENT

The Council deferred action on signing the proposed Diabetes Detection Program Agreement until the October 28 meeting of The Council when the matter could be more fully discussed.

DEATH OF AMA PRESIDENT NORMAN WELCH, M.D.

The Council was informed that MSMS had sent an expression of sorrow to the family of AMA President Welch and that William A. Hyland, M.D., was an honorary pallbearer at the funeral and officially represented the Michigan State Medical Society.

APPRECIATION FROM CITIZENS COMMITTEE ON HIGHER EDUCATION

This letter expressed appreciation for the comprehensive answers supplied to recent questions on the profession of medicine in Michigan.

MSMS PRESIDENTIAL OATH OF OFFICE

The Council approved an official oath of office to be used in ceremonies inducting future MSMS presidents.

GIFT TO MSMS FROM PRESIDENT AND MRS. ORLEN J. JOHNSON

The Council gratefully accepted a gift from President and Mrs. Orlen J. Johnson to cover the furnishings of one of the new conference rooms installed on the second floor of the headquarters in East Lansing to accommodate

additional committee meetings. The Council directed that the President's contribution be noted on a small plaque dedicating the room furnishings to President and Mrs. Johnson.

RETIREMENT PLAN PROPOSAL

The Council authorized that MSMS investment counsel be permitted to use the MSMS addressograph, providing the prospectus and all promotional material regarding suitable retirement plans be submitted to and approved by The Council in advance of release.

DISASTER MEDICAL CARE

The Council approved endorsement of the pilot project of the Bay County Emergency Health Services and approved the proposed goals of the Disaster Medical Care Committee of MSMS for disaster medical care in the state of Michigan.

UNIFORM FEE SCHEDULE

The Council did not adopt the recommendations of the Uniform Fee Schedule Committee, but requested the Committee to restudy the amount of the conversion factor and to present a new recommendation to more adequately represent an average and fair fee.

POSTGRADUATE MEDICAL EDUCATION

The Council approved plans for fall activities of the Postgraduate Medical Education Committee but referred the matter of revision of honoraria for PG speakers back to the Committee for specific recommendation.

REORGANIZATION OF THE COUNCIL

The following officers were elected on September 24:

Council Chairman—Harold H. Hiscock, M.D., Flint; Vice-Chairman of The Council—Robert J. Mason, M.D., Birmingham; Chairman of the Finance Committee—C. Allen Payne, M.D., Grand Rapids; Chairman of County Societies Committee—Ross V. Taylor, M.D., Jackson; and Chairman of Publication Committee—Bradley M. Harris, M.D., Ypsilanti.

STUDY OF COMPANY PRACTICES RE MALPRACTICE INSURANCE

The Council referred this matter to the Finance Committee for immediate action, as outlined in House of Delegates Resolution 32.

COMPARATIVE STUDY OF MALPRACTICE RATES, COVERAGES, ETC.

The Council referred this matter as outlined in House of Delegates Resolution 39 to the Committee on Professional Insurance Plans for study and report.



Among the men receiving 50-Year Pins was Arthur E. Schiller, M.D., Detroit, a former Chairman of The MSMS Council. Doctor Schiller, at right. is congratulated by MSMS President Johnson.



Congratulations are exchanged following their re-elections by James J. Lightbody, M.D., right, Detroit, renamed Speaker of the MSMS House of Delegates, and Louis F. Hayes, M.D., Gaylord, returned as Vice-Speaker.



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Busy Fellow

At times, most physicians active in medical organizations have carried out more than one or two duties at the same time. But here's a short story of a doctor who filled nine different responsibilities at one of the Section meetings during the 1964 MSMS Annual Session . . .

He was Secretary for his Section on Dermatology, Publicist, Acting Chairman, Treasurer and Cashier, Recorder, Projectionist, and Chairman-Elect . . .

And then at the same time during the luncheon, he attended the meeting of the Detroit Dermatological Society as a Member of the Board of Directors . . . and as Secretary.

The busy man was Robert J. Schoenfield, M.D., of Birmingham. (And he's a surprised man to be reading this interesting feature article!)

1965 Blood Symposium Slated for January 22-23

The Thirteenth Annual Wayne State University Symposium on Blood will be held at the Community Arts Auditorium in Detroit, January 22 and 23. The presentation of papers is scheduled to begin at 9 a.m. Friday. On Saturday the scientific session will be from 9 in the morning until 12 noon. A luncheon Friday will also be held at the center. Arrangements have been made for the Friday evening dinner to be held in the Crystal Room of the Park Shelton Hotel.



ANCILLARY SECTION

Migrant Health Projects Under Way in Michigan

The Michigan Department of Health is conducting three migrant health projects, financed by grants from the U. S. Public Health Service. Two other applications are pending.

The three underway include a statewide migrant housing education project conducted by Michigan State University's Agricultural Engineering Department, the improvement of nursing, sanitation, and clinic services provided by the Monroe County Health Department and a similar project conducted by the Ottawa County Health Department.

These latter two community projects have been established with the cooperation and support of local church groups, growers, medical and dental societies, other official county agencies, and others interested in the welfare of the migrant worker and his family.

These projects are made available through the state health department with community group cooperation.

In addition, the State Health Department, planning some statewide migrant health projects in 1965, hopes that a system can be established of correlating activities by various agencies dealing with migrant problems. "Such a system would funnel all activities into one common stream, thus increasing the flow of services to migrants and eliminating the duplication which can cause confusion, waste, and even, in some cases, hard feelings among the various groups," reports the Department.

Michigan ranks third in the nation in numbers of migrants employed, with about 90,000 working each year on a seasonal basis. Housed in some 7,000 work camps, the migrant's average yearly income is about $855; family earnings are probably less than $1,800.

Of Michigan's total farm labor force, 58 per cent are migrants and about 34 per cent of the total farm cash receipts are in crops in which migrants are engaged.

Through a project grant from the Public Health Service, the Michigan Department of Health employed a migrant health consultant in January of this year to provide liaison with all state agencies involved, both voluntary and official, and to stimulate and improve the full use of community health facilities by migrants working in Michigan.

The Department states that, "The core of such facilities, of course, is made up of local health departments which cover 68 of the 83 counties in the state. Each of these is potentially capable of providing a wide range of community preventive health services to migrant workers. However, most of these departments have difficulty in giving special emphasis to the migrant worker because of understaffing and lack of funds to expand programs, even though they recognize the need and are concerned about it. To help these departments, as well as other local community agencies, project grants have been made available through the Public Health Service to provide for special migrant health programs.



Looking over construction plans for the Robert S. Marx Surgical Laboratory are (left to right), Howard Kaichen, of the Marx Trust; Prof. Emeritus Harry Saltzstein, M.D.; Dean Ernest Gardner, M.D.; Prof. Alan P. Thal, M.D., surgery chairman; and Donald S. Schiller, of the contracting company.

$97,300 Remodeling Started At Wayne Surgical Laboratory

Ceremonies have been held to mark the beginning of construction to modernize surgical training and research facilities at Wayne's School of Medicine took place at the surgical laboratory located in the Laboratories of Clinical Investigation Building, 645 Mullett.

Costing $97,300, the renovation of the entire fourth floor of the building was made possible through a $40,000 gift from the Robert S. Marx Trust and $57,300 from the National Institutes of Health.

To be known as the Robert S. Marx Surgical Laboratory, the new unit will consist of biochemistry and other laboratories which will enable the department of surgery to carry out NIH and other research programs, particularly studies of metabolic and structural changes in heart disease, and shock.

Robert S. Marx, after whom the laboratory is named, was a former Detroit and Cincinnati attorney. He died in 1960.

Van Buren, Cass, Berrien Select Health Director

The counties of Van Buren, Cass and Berrien have employed Robert P. Locey, M.D., a native of Kalamazoo, as director of the tri-county health department.

Doctor Locey comes to Michigan from a position as health director of Forsythe County, North Carolina.

Appointment of the director ends nearly two years of work by a tri-county planning committee. The three counties will share in the cost of operating the health program.

MSU Medical Program Given Kellogg Grant

The W. K. Kellogg Foundation recently granted over $1.25 million to Michigan State University for planning and construction of MSU's two-year medical school.

MSU officials point out that the grant allows the University to proceed in applying for federal money under a $236 million medical aid bill signed in 1963. The Kellogg money could be used to match federal funds on a one to two ratio with one MSU dollar for each two federal dollars.

University spokesmen also explain that the Kellogg grant means that the University can move ahead in planning a proposed $6 million Life Sciences Building. The building is expected to be in use by the fall of 1967 at which time the University hopes to be well on its way to a full 50-student enrollment in a medical education.

The Foundation, in making the grant, noted that MSU's new Institute of Biology and Medicine "provides a setting for the College of Human Medicines," and that the Lansing-East Lansing area is ideal for a new school in the state.

"It was found that there are 255 physicians in the Lansing area of whom 99 are certified as specialists," the announcement read.

Other plus factors noted were three major hospitals in the area with 770 beds serving approximately 300,000 people, a total estimated to hit 435,000 by 1980.

This year, MSU has budgeted $145,000 for its medical program, with about $90,000 earmarked for obtaining new faculty members to teach courses in human medicine.

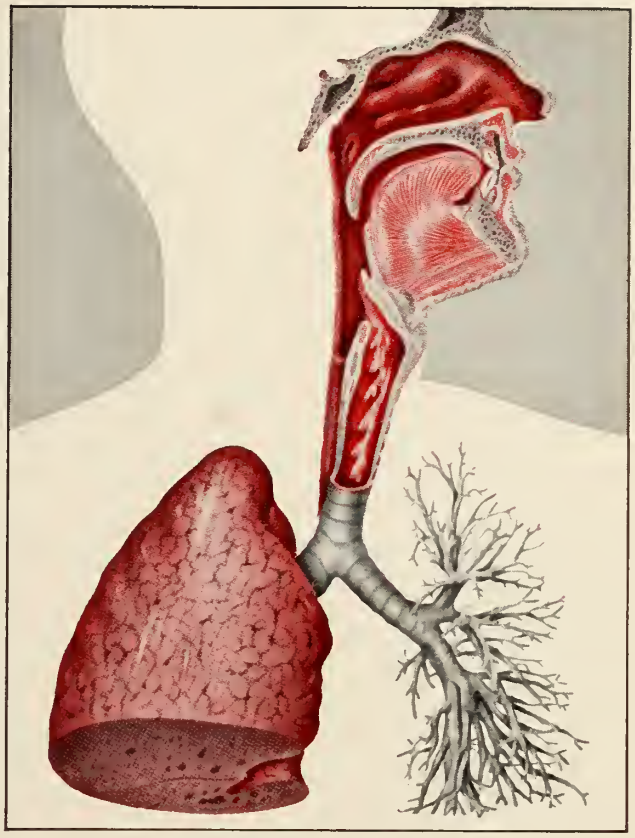
Elect 15 to Blue Shield Board of Directors

Fifteen members were elected to the Board of Directors of Michigan Medical Service at the annual meeting in Detroit, September 22.

The MSMS representatives named were F. S. Alfenito, M.D., Grand Rapids; Hugh Caumartin, M.D., Saginaw; Robert M. Bookmyer, M.D., Birmingham; William R. Gladstone, Jr., M.D., Norway; Robert Stow, M.D., East Lansing; Richard McMurray, M.D., Flint; Benjamin Jeffries, M.D., Detroit.

The following lay members were elected: John Feikens, co-chairman of the Michigan Civil Rights Commission; Alfred M. Pelham, assistant vice-president for finance at Wayne State University; Earl E. Conlin, vice president of Ex-Cell-O Corp.; Howard N. Maynard, president of Snyder Corp.; President Edgar L. Harden of Northern Michigan University; Carl H. Morgenstern, chairman of the board, Old Kent Bank & Trust Co., Grand Rapids. Chosen to represent the Michigan Hospital Association were Julien Priver, M.D., executive vice-president of Sinai Hospital, and Kenneth E. Wolz, administrator of Saginaw General Hospital.

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Each teaspoonful (5 cc.) contains:

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Hydrocodone bitartrate ..... 5 mg.	
(Warning: May be habit-forming)	6.5 mg.
Homatropine methylbromide ..... 1.5 mg.	
Pyrilamine maleate	12.5 mg.
Phenylephrine hydrochloride	10 mg.
Ammonium chloride	60 mg.
Sodium citrate	85 mg.

(with methylparaben 0.13% and propylparaben 0.02% as preservatives)

in a highly palatable cherry-flavored vehicle

antitussive • antihistaminic decongestant • expectorant

treats the multiple symptoms of the COUGH/COLD syndrome

• arrests both productive and nonproductive cough • decongests the airways • liquefies secretions responsible for irritation • provides prompt symptomatic relief of allergic symptoms • is well tolerated • rarely causes constipation

DOSAGE: *Average adult dose*—1 teaspoonful after meals and at bedtime with food. *Children 6-12 years,* ½ teaspoonful; *3-6 years,* ¼ teaspoonful; *1-3 years,* 10 drops; *6 months to 1 year,* 5 drops. Administer after meals and at bedtime with food. On oral Rx where state laws permit.

CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

*U.S. Pat. 2,630,400

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Say you saw it in Michigan Medicine

New Reporting Forms Re Abused Child Laws Available at Hospitals

Act No. 98 of the Public Acts of 1964, commonly referred to as the abused child act, has now become law.

This law states in part "any licensed physician who provides medical treatment or who makes a medical examination of any child under 17 years of age who has physical injuries which were, or may have been intentionally inflicted upon him by any person responsible for his care, shall immediately cause a report to be made as required by this act. . . ." "The report required in section one shall be made in triplicate and one copy shall be mailed to the prosecuting attorney and to the department of social welfare of the county where the physician believes the injury may have been inflicted. One copy shall be mailed to the Lansing office of the State Department of Social Welfare."

For the convenience of physicians in complying with this act, the State Department of Social Welfare has developed a standardized reporting form which has been distributed to all hospitals by County Departments of Social Welfare.

The State Department of Social Welfare will also act as a centralized source of information for the accumulation of such reports and the dissemination of information concerning repeated reports of abuse to children.

Epidemiology Conference Speakers Set for Lansing, Dec. 16-18

Albert P. Iskrant, M.D., Chief, Developmental Research, Division of Accident Prevention, U. S. Public Health Service, Washington, D. C., will be the principal speaker at The Michigan Department of Health Epidemiology Conference at the Jack Tar Hotel, Lansing, December 16-17-18. Doctor Iskrant will address a dinner meeting at 6:30 p.m. on Wednesday, December 16, on "Epidemiology of Accidents."

Other nationally-known speakers coming include Tadeusz Wiktor, M.D., of Wistar Institute, Philadelphia, who will speak on "A New Vaccine for Human Prophylaxis"; David Sencer, M.D., Deputy Chief, CDC, PHS, Atlanta, Georgia, on the art and technique of tuberculosis control identification, evaluation and follow-up.

Reservations for the dinner meeting may be made through the Division of Adult Health, Michigan Department of Health, Lansing.

Next Genesee Diabetes Day, 1965

The Genesee County Medical Society reports it will hold its next Diabetes Day in November, 1965. (There will be no Diabetes Day in 1964.)

Winners Listed In Auxiliary Art Show

Winners in the various divisions of the Annual Art Show for Michigan physicians and their wives, in conjunction with the MSMS Annual Session in Detroit were Mrs. Emerick Szilagy, Bloomfield Hills, oils; Lawrence Koltonow, M.D., Rochester, sculpture; Mrs. L. Jerome Fink, Pontiac, ceramics; Mrs. Jay Rosenbaum, drawing; Mrs. Mark Dale, Birmingham, jewelry; Mrs. Herman Linn, Bloomfield Hills, weaving, and M. W. Jocz, M.D., Grosse Pointe Park, water color.

A water color by Doctor Jocz, declared "Best in Show," was entitled "Snow Scene."

The show was sponsored again by the Woman's Auxiliary to the Michigan State Medical Society.

National Meet in Detroit Picks Rehabilitation Topic

The 1964 annual convention of the National Society for Crippled Children and Adults, November 13-16 at the Statler-Hilton Hotel, Detroit, will focus on rehabilitation services. Authorities in the rehabilitation field will conduct seminars and workshops and present new concepts to professional workers and a large number of volunteers are expected to attend.

The important job that teen-agers are doing in working with the handicapped will receive special attention during the convention.

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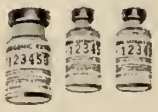


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PUBLIC RELATIONS

Sees Communications Vital to Unity of Profession

"Communications is vital to unity."

So stated Milford O. Rouse, M.D., Dallas, Texas, in his address to the MSMS House of Delegates in Detroit. Doctor Rouse is Spcaker of the AMA House of Delegates and was introduced by William A. Hyland, M.D., Grand Rapids, chairman of the MSMS delegation to the AMA. Doctor Rouse continued: "If we work together, if we open more paths of communication and cooperation between our various societies and between us and the people of this Nation—then we can bring into being the goal sought by every physician who would follow our Oath."



"In the future," pointed out Doctor Rouse, "the medical profession must be united. We must stand strong and firm with a heart and conscience turned to public need with a respect for the rights and privileges of the individual, and with an abiding faith in our free competitive system of medical practice."

As he discussed cooperative effort, Doctor Rouse especially lauded Michigan by saying, "You have achieved good rapport between the full-time medical school teachers and the physicians in private practice, working together for common goals."

Albert Myers, M.D., Potterville, can be proud of the trophy presented him by Olivet College in recognition of his outstanding community service as a leader in educational matters.

Traits Suggested for Physician of Tomorrow

What manner of man should the physician of tomorrow be?

Advice to answer that question is given by F. J. L. Blasingame, M.D., Executive Vice President of AMA. He suggested in a recent speech in Wisconsin that "As always, the physician should have in good measure the following:

"1. An awareness of the past, an alertness to the present, a faith in the future;

"2. A thirst for knowledge and a hunger to expand it;

"3. Tenderness enough to treat compassionately;

"4. Toughness enough to tackle tyrants;

"5. A sensitivity to professional responsibility;

"6. An abundance of courage;

"7. A tendency to be a spendthrift with his talents;

"8. Technical competence;

"9. Intelligence sharpened by wisdom;

"10. A tolerance of a fault in others; and

"11. A sense of humor, especially when the joke is on him."

Doctor Blasingame then concludes: "With these elements, well blended with others, and properly seasoned, the physician should be able to measure up creditably to the opportunities of our great profession in the tomorrows. He will be needed as never before to meet the increasing desire for good health among the people. He will be respected and granted freedom and privileges which his work will require. Finally, he will spend a fruitful, effective life and be rewarded by profound satisfactions."

Where Would We Be?

It is generally agreed that what our country needs today is patriotism, nationalism, morality, courage, dedication, and religion, and in a way that these have never been needed before.

These virtues are not the attributes of the modern "angle players," declared James E. Palmer, Jr., a professional staff member of the U. S. Senate Committee on Banking and Currency, in a commencement address.

Had they been angle players, he said, some of our national heroes might have answered the call to duty like this:

Paul Revere: Why pick on me? It is the middle of the night. I cannot ride through every Middlesex Village. Besides, I am not the only man in Boston with a horse.

Benjamin Franklin: I'm over 75 years old. What you need as a Minister to France in these strenuous times is a younger man. Let a new generation take over. I want to rest.

—*Texas State Journal of Medicine*



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A custom-made Jobst

Venous Pressure Gradient Support enables the doctor to prescribe adequate counter pressure to relieve and control even the most severe vascular and stasis problems.

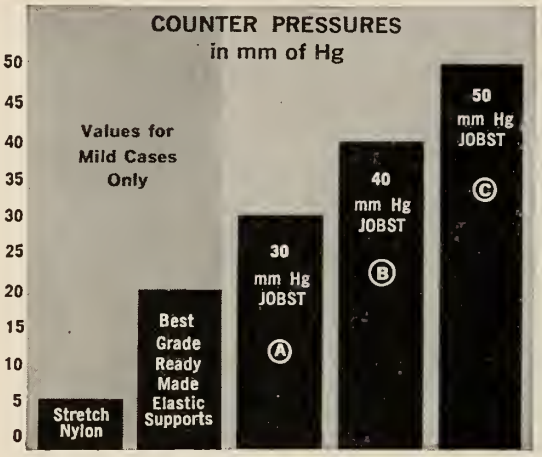
The chart at right shows limits of counter pressure with other supports (ready-made), which restricts their therapeutic values to mild cases.

Each Jobst Support is custom-engineered to the precise measurements of a patient's extremities. It is guaranteed to fit any limb, any shape, any size . . . without strangulation, puddling or tourniqueting. Choice of counter-pressures. Jobst Stockings are available in any length, including waist height (leotard); also post-mastectomy sleeves. *Send patients for measurements to*

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In sinusitis, colds, U.R.I., Dimetapp lets your "stuffed-up" patients *breathe easy again.* Each long-acting Extentab provides clear relief for up to 10-12 hours, yet seldom causes drowsiness or overstimulation.

BRIEF SUMMARY: ***Indications:*** Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. ***Side Effects:*** In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. ***Precautions:*** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. ***Contraindications:*** Antihistamine sensitivity. Not recommended for use during pregnancy.

*Clinical report on file, Medical Department, A.H. Robins Co., Inc.

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THE ULCER LIFE

In this "pop art" assemblage, artist Bob Sullivan depicts "the ulcer life" as man-in-a-box. The wall of nails closing in might well symbolize the torturous demands of a rigid, conformist society. As for the man, his disembodied psyche moves relentlessly onward with the blank, fixed stare of a man who has lost control of his own destiny. Small wonder that his gastric mechanism rebels.

NUMBER 1 IN A SERIES

for the ulcer life:
a new strength of glycopyrrolate

ROBINUL® FORTE
2 mg. per tablet

ROBINUL®-PH FORTE
glycopyrrolate 2 mg. phenobarbital 16.2 mg. (warning: may be habit forming)

When glycopyrrolate was first introduced, clinicians were immediately impressed by the remarkable ability of this compound to exert a more specific pharmacologic action on the gastrointestinal tract than on other organ systems. For example, they often found that in difficult patients the dosage could easily be adjusted upwards to achieve the desired suppression of both hypertonicity and secretion . . . without paying the penalty of side effects intolerable to the patient. Thus, it is no surprise that many clinicians suggested that a double-strength 2 mg. tablet of glycopyrrolate would be both practical and useful. For those patients ordinarily unresponsive to anticholinergics or for those exhibiting the more prominent symptoms, the new Forte dosage forms are a worthwhile addition to your ulcer armamentarium.

BRIEF SUMMARY

INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

DOSAGE: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime.

See product literature for full prescribing information.

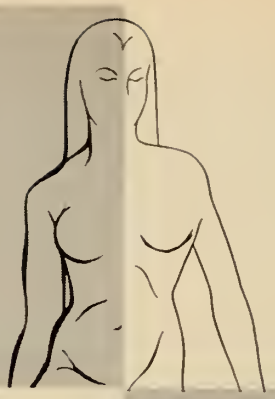
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Each **CYDRIL** (levamfetamine succinate) Granucap* contains:
levamfetamine succinate 21 mg.
(Releasing the drug over a 6-10 hour period)

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Side Effects: Rare—C.N.S.** stimulation minimal, occasionally cardiovascular and gastrointestinal reaction may be observed.
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THE 88TH CONGRESS IN REVIEW

Adjourning on Saturday, October 3, the 88th Congress passed into history. By almost any measure, the 88th had a busy and eventful two-year term. Approximately 20,000 bills had been introduced in the House or Senate. Of these, 850 affected medicine, medical care, or the public health.

The AMA presented its views on pending legislation on 25 occasions as well as providing 16 informational statements to various committees of Congress. It took nearly 61,000 pages in the *Congressional Record* to record the 88th Congress' deliberations of the various proposals which came before it. In addition, many more thousands of pages of testimony were recorded in the published proceedings of the public hearings which were held in connection with pending legislation. For example, the hearings of the House Ways and Means Committee on H.R. 3920, the King-Anderson bill, filled five volumes and ran to over 2,500 pages.

Some of the more major measures of medical interest which were enacted into law were: the Health Professions Educational Assistance Act which provides construction grants for the construction of teaching facilities and a student loan program; Maternal and Child Health and Mental Retardation Planning Amendments providing grants to help meet the cost of special projects, research, and other activities; Mental Retardation Facilities and Community Mental Health Centers Construction which authorizes grants for the construction of research and clinical facilities, and for community mental health centers; Clean Air Act expanding the federal government's role in air pollution control; Hospital and Medical Facilities Amendments which extended for five years the Hill-Burton hospital construction grant program and adding to it, grants for the modernization of existing facilities and for areawide health facilities planning programs; and the Nurse Training Act authorizing grants for the construction and modernization of nursing schools, and establishing a loan fund for student nurses.

Several other bills of interest to medicine failed to gain approval of both houses of Congress, and died with the adjournment of the 88th Congress. Included were: a water pollution control measure; reorganization of the U. S. Public Health Service; the creation of an "Office for Senior Citizens" in the Department of Health, Education and Welfare; the King-Anderson medicare-tax proposal; chiropractic care for federal employees under the Federal Employees' Compensation Act; a psychotoxic drug control program; and a bill which would have exempted nonprofit blood banks from the antitrust laws.

Many of the measures which were not favorably acted upon during the 88th Congress will be reintroduced after the 89th Congress convenes on January 4, 1965.



LEGISLATIVE AFFAIRS

More Social Security Benefits Denied by Medicare Supporters

A House-Senate conference committee deadlocked over the Johnson Administration's so-called medicare proposal before adjourning to campaign for the November elections.

It meant the death of such legislation for this year unless Congress should be called back in special session after the elections for further consideration of the legislation by the conference committee.

However, medicare supporters said they would revive the issue next year and make another attempt to get Congressional approval for hospitalization for the aged financed by a social security tax increase.

Failure of the committee to reach agreement on medicare also killed a cash increase in social security benefits. The House overwhelmingly voted for the cash increase. The Senate voted 49 to 44 to add an administration proposal that would have financed some hospitalization and nursing home care for the aged under social security.

Congressman John W. Byrnes (R-Wisc.) pointed out that the pro-medicare senate conferees had denied an increase in social security cash benefits by refusing to have any bill approved if it didn't include medicare.

"Adequate cash benefits and medicare cannot both be financed through a social security tax," Byrnes said. "Adoption of the Senate amendment would make it impossible, as a practical matter, to adjust cash benefits in order to meet increase in the cost of living. Cash benefits under social security would be 'frozen.'"

Meantime, the federal-state Kerr-Mills is paying part or all of the costs of medical care, including hospitalization, for thousands of aged Americans who need such help.

IN MEMORIAM

HAROLD M. FOX, M.D.

Harold M. Fox, M.D., 66, Portland physician for 32 years, died September 19, 1964.

A graduate of the University of Michigan Medical School, Doctor Fox interned at St. Mary's Hospital, Grand Rapids, and practiced a year in Owosso before moving to Portland.

CHARLTON A. MACPHERSON, M.D.

Charlton A. Macpherson, M.D., former St. Clair physician, died September 3, 1964, in Louisville, Kentucky, where he had lived for the past several years.

Doctor Macpherson was a graduate of the University of Toronto medical school and served his internship at Harper Hospital, Detroit. He began his practice in St. Clair in 1915 and practiced there until his retirement in 1948 because of ill health. He was on the staff of St. Clair Community Hospital.

Doctor Macpherson was a Retired Member of the Michigan State Medical Society and was a member of Rotary International.

ALEXANDER R. McKINNEY, M.D.

Alexander R. McKinney, M.D., 79, Saginaw physician, died August 29, 1964.

A 1907 graduate of the University of Michigan Medical School, Doctor McKinney interned at a Pittsburgh hospital before beginning his practice in Saginaw in 1908. He served in Saginaw for nearly 54 years until his retirement in 1962, beginning his career as a general practitioner and later specializing in ophthalmology.

Doctor McKinney was a Life Member of the Michigan State Medical Society, and a Fellow of the American College of Surgeons and of the American Academy of Ophthalmology and Otolaryngology. He also held membership in many other professional organizations.

RAYMOND L. PAINE, M.D.

Raymond L. Paine, M.D., 56, Negaunee health officer, died unexpectedly August 28, 1964.

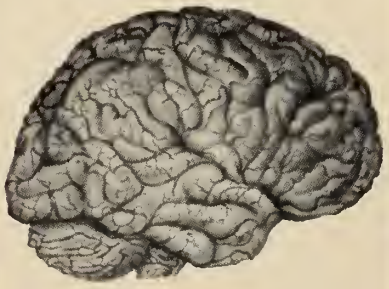
Doctor Paine was graduated from the University of Michigan Medical School and served his internship there, followed by a period on the surgery staff at University Hospital.

Doctor Paine practiced in Negaunee from that time until his death, excepting a period of military service during World War II. He had been municipal health officer in Negaunee since 1950.

He was a member of Pi Kappa Pi fraternity and

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increases blood flow...



IN CEREBROVASCULAR INSUFFICIENCY
where vascular insufficiency may cause such symptoms as mental confusion, diplopia, fatigue, apathy, and behavior problems.



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where ischemia causes muscle distress—pain, spasm, ache, intermittent claudication; also coldness, numbness or ulceration of extremities.

Nu Sigma Nu Medical Fraternity. He was on the staff of Bell Memorial Hospital, and was its chief of staff in 1961. He was also a member of the board of trustees at Morgan Heights Sanatorium.

PAUL S. RUTHERFORD, M.D.

Paul S. Rutherford, M.D., 50, Kalamazoo pathologist, died September 2, 1964.

Doctor Rutherford received his medical degree from Queen's University in Kingston, Ontario, in 1940. He completed postgraduate work in pathology at the University of Toronto, Kingston General Hospital and Mayo Clinic.

Doctor Rutherford had been Borgess Hospital pathologist since 1956. He was also pathologist for Dowagiac Hospital. He was a Fellow of the College of American Pathologists.

MARVIN D. UTLEY, M.D.

Marvin D. Utley, M.D., 42, of Wilmington, Delaware, former staff physician at Lapeer State Home and Training School, died August 14, 1964.

Doctor Utley was on the Lapeer staff from 1956 to 1959, when he transferred to Ypsilanti State Hospital to begin his residency in psychiatry. Subsequently he took further training at Pontiac State Hospital and Delaware State Hospital in Farnhurst, Delaware.

He was an Associate Member of the Michigan State Medical Society.

LESLIE L. WILLOUGHBY, M.D.

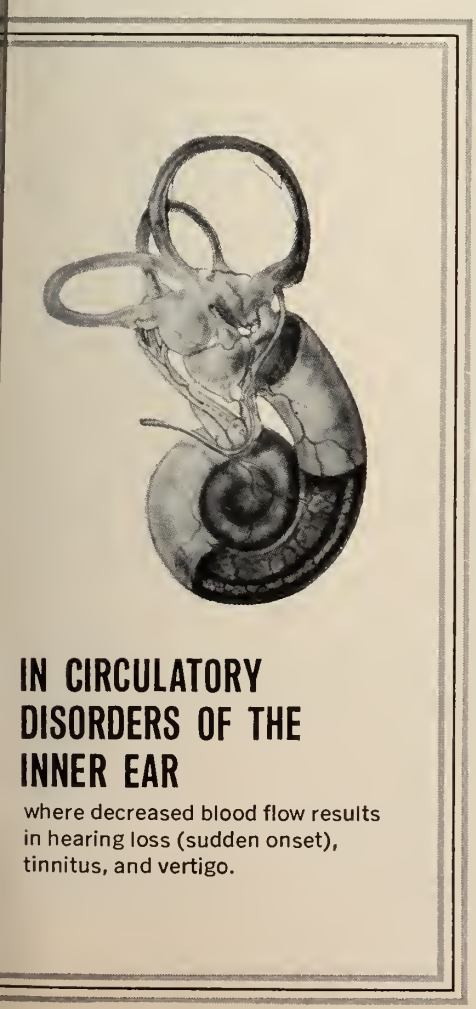
Leslie L. Willoughby, M.D., 88, of Marine City, died August 23, 1964.

A 1905 graduate of the Michigan College of Medicine and Surgery, now part of Wayne State University School of Medicine, Doctor Willoughby practiced in Mancelona until 1916, and in Flint from 1916 to 1956. He moved to Marine City in 1956 when he retired from practice.

He was on the staffs of Hurley, McLaren General and St. Joseph hospitals in Flint at the time of his retirement. Doctor Willoughby was a Past President of the Genesee County Medical Society and a Life Member of the Michigan State Medical Society.

Dow Corning Offers Booklet

A new, eight-page brochure, "Subdermal Implant Materials," describing Silastic medical-grade silicone elastomer and prosthesis made from this material, is available from Dow Corning Corporation, Medical Products Division, Midland.



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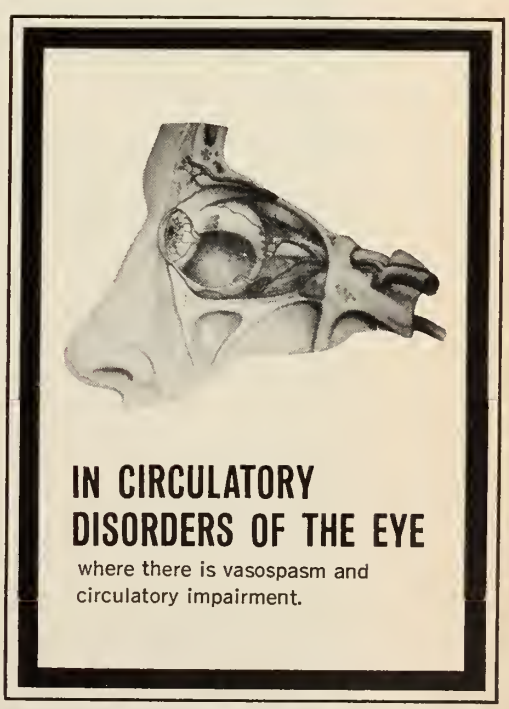
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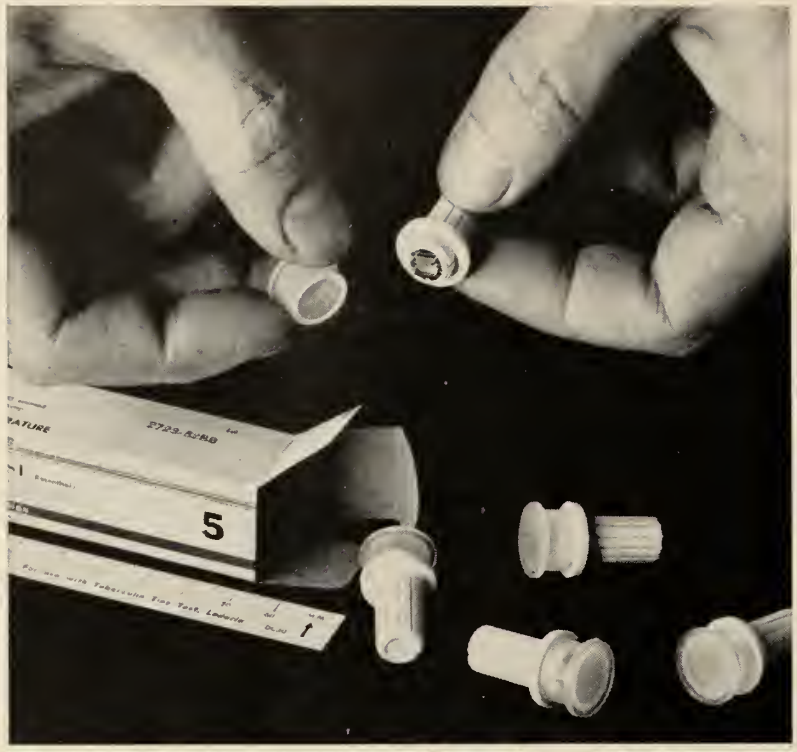
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where there is vasospasm and circulatory impairment.

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State MAA Payments Total $30.9 Million

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The federal government provided about $15.0 million of the $30.9 million for the Michigan Kerr-Mills program.

Of the 59,636 Michigan OAA beneficiaries, 10,212 were hospitalized during the fiscal year, and 6,381 were treated by physicians.

Under MAA, 14,121 were hospitalized, 1,356 received care in nursing homes and 6,552 had physicians' services.

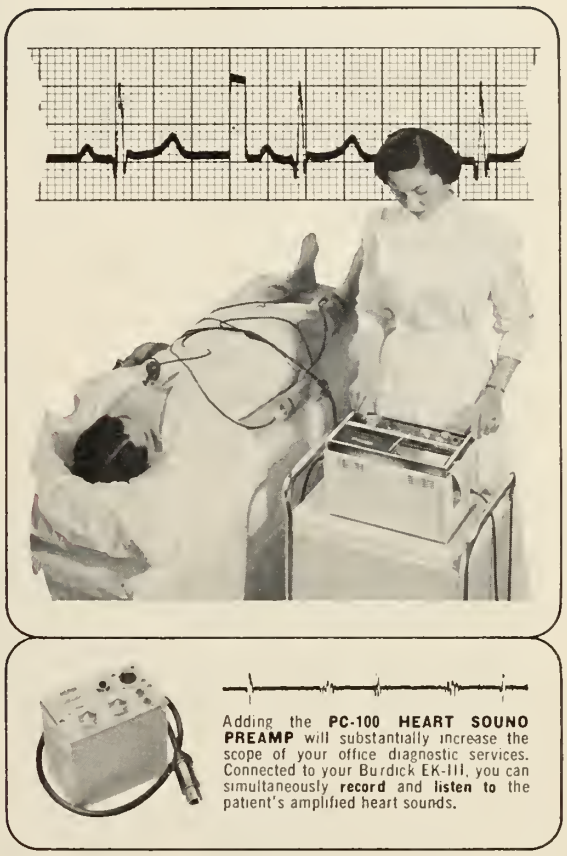
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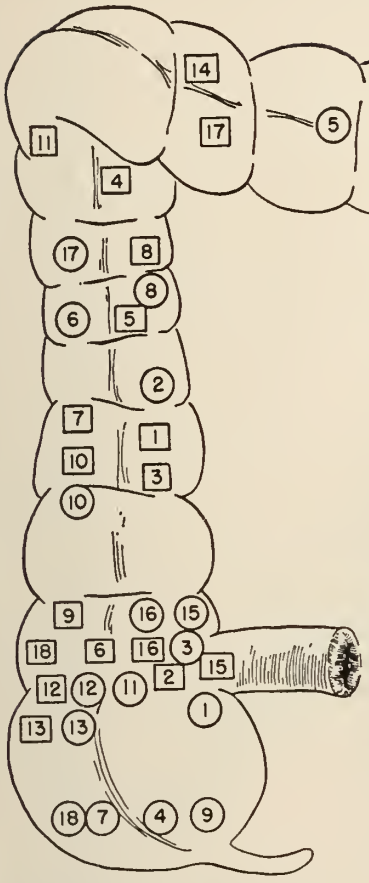


Figure 3-25. *Location of cancer and simple adenomas in resected cancers of the right colon. Squares locate cancers; circles, adenomas.*

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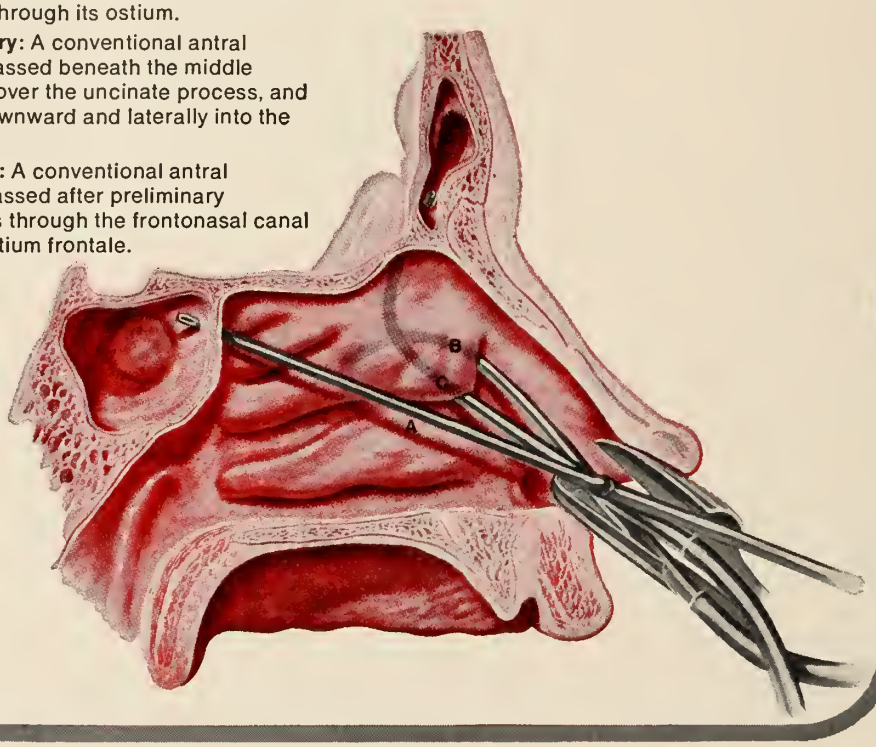
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President's Message

Planning Medicine's Future

By Oliver B. McGillicuddy, M.D.
MSMS President

Seven hundred doctors work for the Michigan State Medical Society and its seven thousand members. They serve on one or more of the sixty committees of the Society and attend most of their committee meetings.

Some of these doctors, officers and councilors spend twenty to thirty days and nights a year. A few committee chairmen and their committee members spend half this much time. Why? Why do these doctors take time from their practices, their families and their leisure activities? Obviously they are dedicated individuals who are gratified by the contribution they are making to organized medicine.



* * *

What of the other ninety per cent of the membership? Many are giving nearly as much time working for their county societies and on hospital committees. Some are deeply involved in civic and community enterprises or vigorously supporting their churches and schools.

Some doctors think they are literally too busy caring for the sick to have time for anything else; however, many of the most devoted workers in organized medicine have just as large practices.

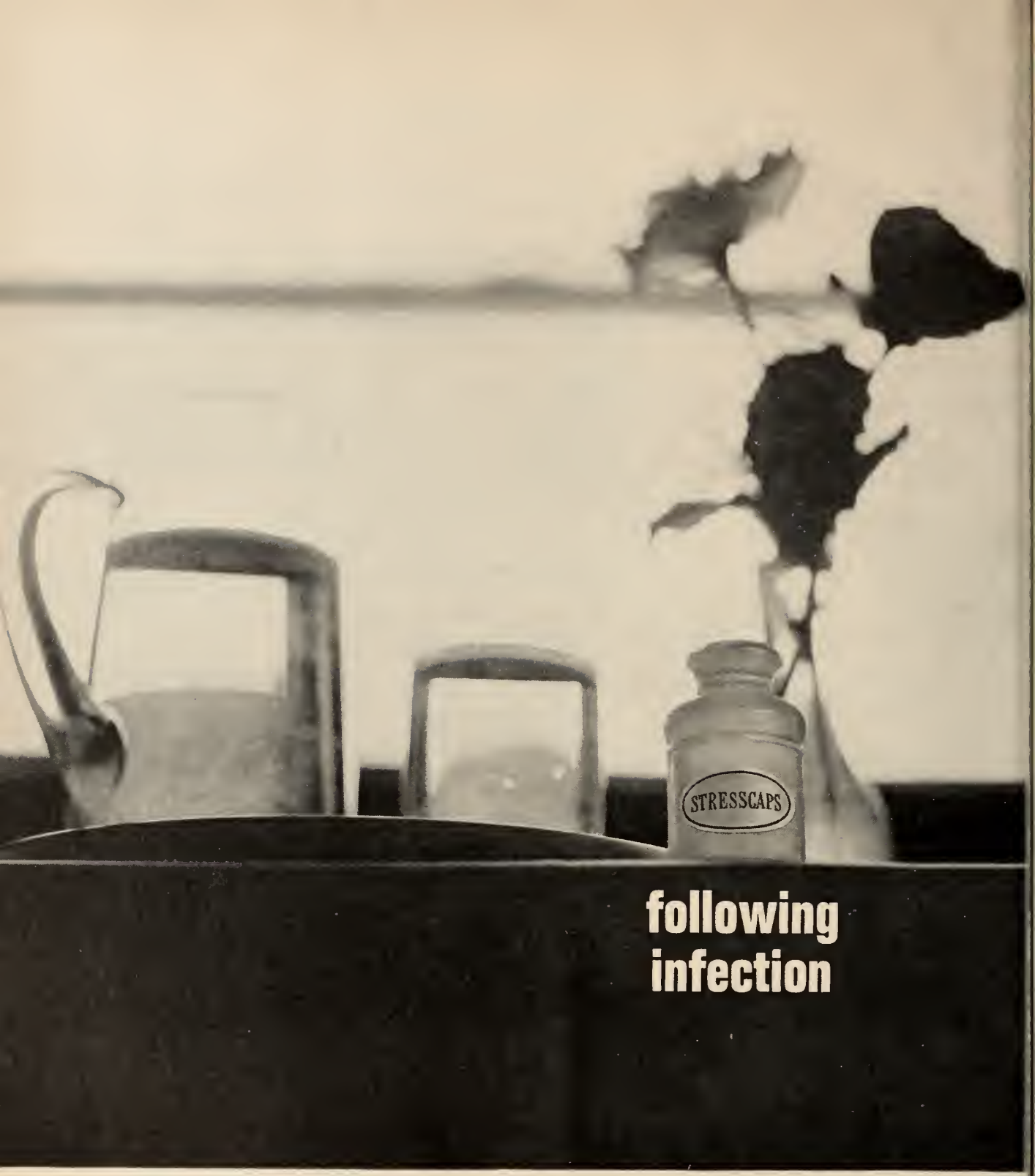
A great many of these workers have served for years. There is a crying need for young blood not only in the State Society but in local activities, civic as well as medical.

On a current survey of the problems of state medical associations there is a discouraging repetition of the question, "How do you interest young doctors in the problems of organized medicine?"

* * *

The future of medicine belongs to the young and their help is needed in planning and fighting for that future.

All they need to do is to show an interest and be willing to give some of their time and they will find both in civic organizations and in their county and state medical societies that they will be received with enthusiasm. Then they will know the gratification that comes from having a part in the planning of medicine's future.



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INFORMATION FOR READERS / CONTRIBUTORS:

GENERAL INFORMATION:

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. A copy is sent to each member of the Society.

Notice of change of address should be sent promptly to the Michigan State Medical Society, P.O. Box 152, East Lansing, Michigan.

Members are invited to submit to the Journal any suggestions for the welfare of the Society, as well as comments or criticisms of any material in the Journal. All such communications should be directed to the Publication Committee of the Journal. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted to it.

ADVICE TO AUTHORS:

1. Address scientific manuscripts to Editor, MICHIGAN MEDICINE, C. J. Tupper, M.D., 2490 Adare, Ann Arbor, Michigan.

2. Submit original, double-spaced, typewritten copy and one carbon copy on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

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6. References will ordinarily be limited to seven in number. Exceptions may occasionally be made.

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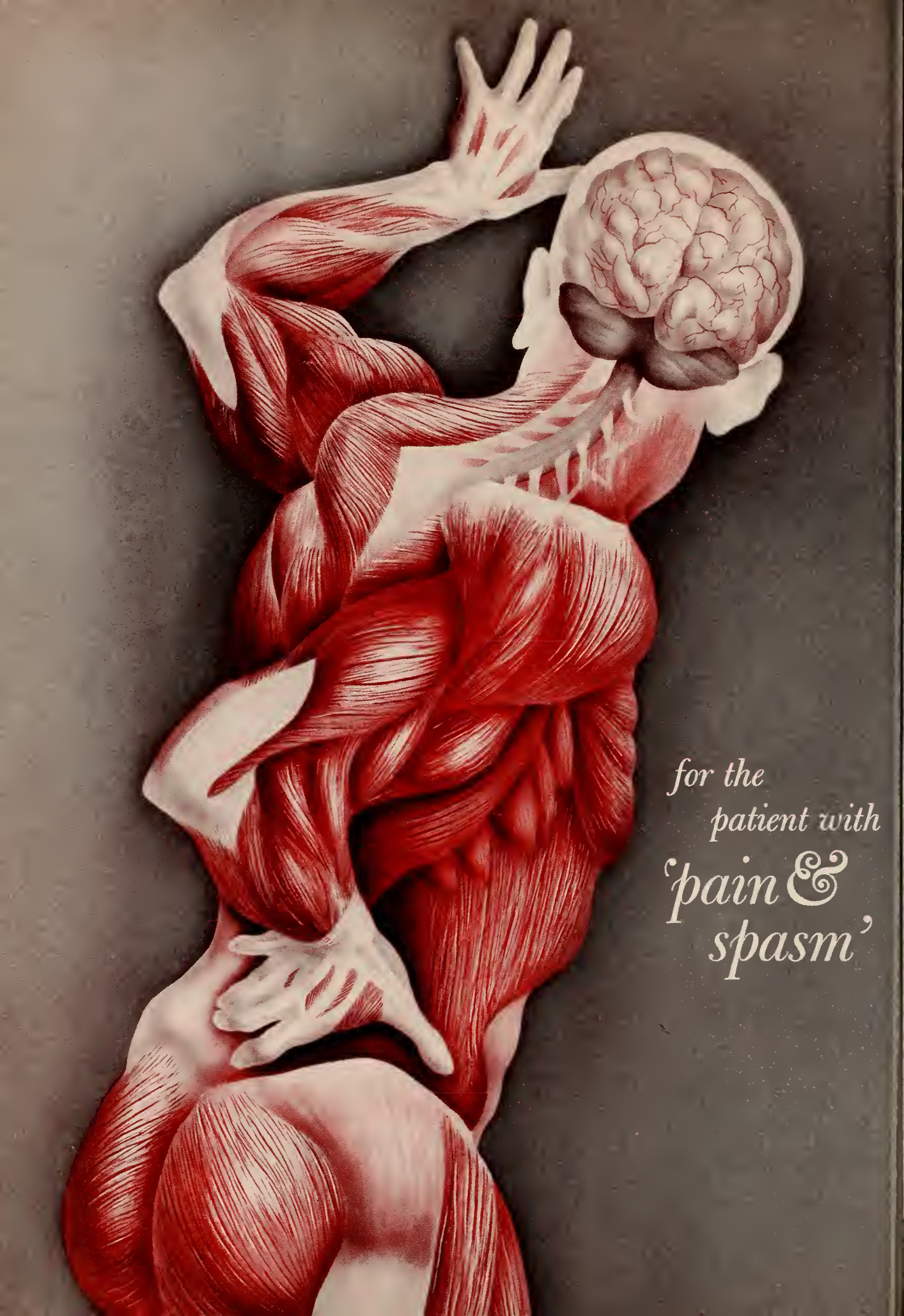
8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus*, including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in MICHIGAN MEDICINE.


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Pain *is almost invariably a presenting symptom in cases of skeletal muscle* *spasm*

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1. Kunin, C. M., Dornbush, A. C. and Finland, M.: J. Clin. Invest. 38:1950, Nov., 1959.



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Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated.

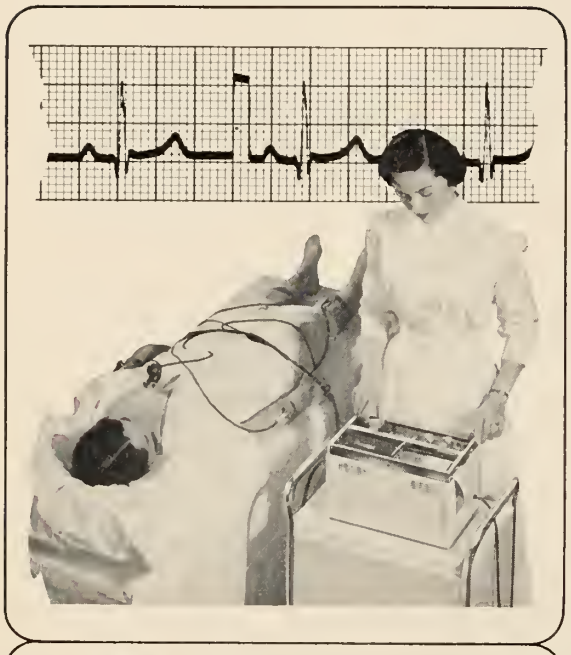
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NEWS BRIEFS

Nine countries of Europe were visited by **Mary Cretens, M.D.**, director of the Delta Menominee Health Department, with 28 doctors on a public health and health education tour.

Nicholas Lentini, M.D., Cheboygan, received a plaque-mounted electric clock from the Cheboygan County Unit of the American Cancer Society in appreciation of his 20 years of service as Medical Chairman.

A 40-member citizens advisory committee for the Fenton area schools is being led by Chairman **Ralph Ettinger, M.D.**, Fenton. The study of four school districts will end early in 1966.

Chrysler has named **Monroe S. Lechner, M.D.**, East Detroit, as group medical administrator-power train. He will be responsible for advising, counseling and directing medical departments in 16 plants in the Chrysler Power Train Group in Michigan, Indiana and New York.

Governor Romney recently renamed **Roger W. DeBusk, M.D.**, Detroit, and **John R. Rodger, M.D.**, Bellaire, to the Michigan Advisory Hospital Council for 4-year terms. The appointments require Senate confirmation.

John W. English, M.D., Marquette, discussed "Diagnosis and Medical Management of the Heart Attack Patient" at a conference of Upper Peninsula nurses at Marquette. **Paul Clodfelder, M.D.**, Grand Rapids, participated in a closed chest cardiac resuscitation demonstration there.

M. K. Newman, M.D., Detroit, delivered addresses at the annual meeting of the Wisconsin Society of Internal Medicine, Delavan, Wisconsin, on October 10, about "Chemistery of Muscle Disease," and "Clinical Management of Chronic Muscle Disease—Rehabilitation."

A series of eight weekly lectures about "Psychopharmacology" is being given at the Sinai Hospital, Detroit, by **E. F. Domino, M.D.**, U-M professor. The series continues Wednesday nights through December 30.

Say you saw it in Michigan Medicine

One of 12 Air Force ROTC Outstanding Service Awards in the nation was given to **James S. Feurig, M.D.**, East Lansing. A former flight surgeon, Doctor Feurig was cited for continued support of the Air Force ROTC at MSU.

David C. Boyce, M.D., Grand Rapids, was elected a vice president of the Flying Physicians Association at the annual meeting in Palm Springs. The Association was founded in 1954 to promote general aviation safety and to assist in the nation's civil defense effort.

Clarence L. Candler, M.D., Detroit, who served as treasurer of the Wayne County Medical Society for the past 14 years, resigned recently because he is moving to St. Clair to live and engage in limited practice.

George E. Moore, M.D., director of the Roswell Park Memorial Institute at Buffalo, speaker at the 1964 Michigan Clinical Institute, recently received the 1964 Bronfman Prize for Public Health Achievement at the annual meeting of the American Public Health Association.

Reed O. Dingman, M.D., has been appointed head of the newly-established Section of Plastic Surgery in the Department of Surgery at the University of Michigan Medical School and University Hospital. Dr. Dingman has been a member of the U-M faculty since 1933.

L. Jerome Fink, M.D., Pontiac, discussed "Detecting Early Symptoms of Mental Illness" at a Grand Rapids conference on "Problem Behavior in Industry —Early Recognition and Followup," sponsored by the Michigan Society for Mental Health.

A review of cancer research was presented by **W. Alan Chickering, M.D.**, Berrien County Medical Society President, at a meeting of the Scientific Research Society of America at the Whirlpool Research Laboratories in St. Joseph.

James H. Beaton, M.D., Grand Rapids, is the first president of the newly-organized Dr. Frank Doran Foundation for Medical Education at Grand Rapids. The non-profit foundation to promote medical education and research honors Doctor Doran, who recently retired after many years as chief of staff at St. Mary's Hospital. Other Foundation officers include **Joseph R. Lentini, M.D.**, Vice President.

Armada recently paid its thanks to **Allen B. Bower, M.D.**, who has practiced there for 50 years, at an open house at the Armada High School.

Gerald P. Hodge, associate professor of medical illustration in The University of Michigan Medical School, has been elected president of the Association of Medical Illustrators, an international organization.

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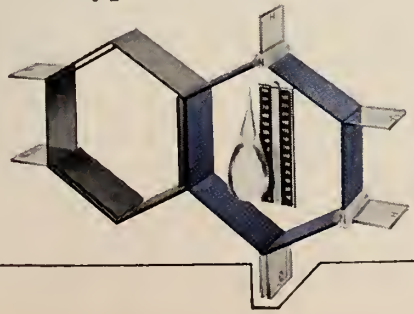
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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The discharged mental patient . . . and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. 27:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

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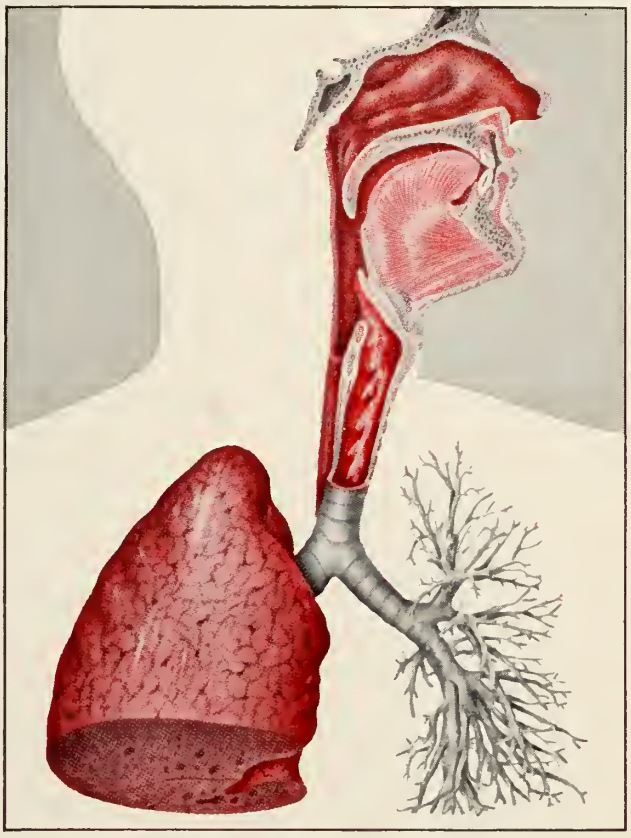
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CAUTION: Should be used with caution in patients with known idiosynerasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

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75,000	37,500	81.00
50,000	25,000	54.00
25,000	12,500	27.00

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Say you saw it in Michigan Medicine



See Page 859 for this case

TRAUMATIC DEFORMITIES OF THE NOSE

By G. JAN BEEKHUIS, M.D.
Detroit

INTRODUCTION

The nose, as an integral part of the upper respiratory tract and as a major component of the facial features, has many functions. These have to do with respiration, phonation, olfaction, filtration of inspired air and drainage. As a noticeable feature of the face, the nose also has the aesthetic purpose of appearance. In evaluating nasal dysfunction and performing nasal surgery, the physician must keep in mind all of these functions.

Today, many of our patients are no longer satisfied with merely having an open nasal passage. They also would like to breathe comfortably and in addition, to have a nose which is in harmony with other facial features.

* * *

IT IS IMPERATIVE that the rhinologist who deals with nasal function utilize the surgical principles of rhinoplasty. In a large number of cases, it immediately becomes apparent to the trained eye that patients with nasal dysfunction also have major or minor nasal deformities. Some of these may not be grossly obvious but are nevertheless real and can lead to nasal dysfunction. From an aesthetic standpoint, they can be of great concern to the patient.

Doctor Beekhuis is Professor and Chairman, Department of Otolaryngology, Wayne State University, School of Medicine.

ETIOLOGY

The etiologic factors involved in nasal deformities are:

1. *Hereditary Factors.*—Many nasal deformities, e.g., hump deformities, cleft tip, etc., are inherited.



SCIENTIFIC PAPERS

Most of these do not become obvious until after puberty.

2. *Racial Factors.*—The classic Greek nose has no naso-frontal depression and a straight dorsum on profile view; the classic Roman nose has a slightly convex dorsum. It is generally agreed that the semitic races are more prone to a dorsal hump and to septal deviation. The negroid nose has a flat, broad dorsum with wide flaring alae.

3. *Trauma.*—The nose, as the most exposed and prominent feature of the face, is vulnerable in most facial injuries. Nasal trauma leading to subsequent nasal deformities, may be classified in three groups:

A. Major trauma in adulthood
B. Prenatal and childhood trauma
C. Iatrogenic (generated by the physician)

A. MAJOR TRAUMA IN ADULTHOOD

There is no doubt that fractures and dislocations of the nasal bones and cartilages and the nasal septum are very common. Becker[1] found that in a study of 135 cases of nasal trauma, 100 presented fractures. In adults most of these deformities are readily visible to the patient and to the physician. Allowing for ecchymosis and edema, the patient notices a change in the appearance of the external nose and some airway obstruction. The optimum time to correct these deformities is either in the immediate post-traumatic period or as soon as possible after edema has subsided so that careful visual examination and palpation can be carried out.



Fig. 1. Preoperative and postoperative views; Case M.G.
History: Nasal trauma.
Examination: External deviation to the right, septal deviation, bony and cartilaginous hump formation. Small nasal labule angle.
Procedure: Septal reconstruction, removal of hump, medial and lateral osteotomies and tip reconstruction.

* * *

THE PRINCIPLES of the early reduction of nasal fractures will not be discussed in this paper.[2] However, it should be pointed out that many of these injuries are associated with injuries of the nasal septum and that these should be corrected simultaneously. The realignment of fragments in the nasal septum is important not only from a functional airway standpoint but also because it gives the necessary support for the nasal dorsum.

"As the nasal septum goes, so goes the nose."[3] This concept has been stressed by many authors[1,4,5] and its importance is obvious to anyone interested in nasal and septal reconstructive surgery. The nasal framework and septum may be likened to a tent, the septum forming the central supporting tent pole. In nasal fractures where the nasal bones have lost their attachments, the central supporting framework becomes doubly important.

Unfortunately, many of these nasal injuries are ignored by the physician or the patient or both, and in time multiple nasal deformities with all their sequelae are the result. Once the individual fractured elements have healed in a new position, it becomes necessary to free completely all elements and realign them in their proper position. Consequently a complete nasal and septal reconstruction is indicated. In these cases the surgeon cannot ignore either the functional airway problem or the aesthetic appearance. Both are related and can be corrected simultaneously.

* * *

COMMON SEPTAL deformities are: dislocation of the anterior end of the quadrilateral cartilage, inferior dislocations of the cartilage resulting in a large spur near the floor of the nose and minor or major septal deflections, obstructing one or both nasal cavities (Figs. 2, 3 and 4).

As will be pointed out under iatrogenic causes, it is important that correction of these septal deformities be handled conservatively. Wide resection of the nasal septum which gives a perfectly cosmetic septum may seriously hamper the subsequent correction of the external nose and may lead to further deformities. In these cases, it is imperative to resect as little as possible of the septal framework and it is definitely preferable to liberate the dislocated or deviated portion and return it to its natural position. The end result may not always be a perfectly smooth, straight septum, but this is not necessary or even desirable as long as the nasal



Fig. 2: Preoperative and postoperative views; Case E.P.
History: Previous nasal trauma and surgery; almost complete obstruction, left nostril.
Examination: External deviation to right; small bony exotosis on left lateral nasal wall, asymmetry of tip, small bony hump and a relative saddling. Marked septal dislocation to left. Septum buckled and large perforation present.
Procedure: Septal reconstruction, hump removal, osteotomies and infracture, removal of exotosis, tip reconstruction.

airway is completely adequate. Very few so-called normal noses have a perfectly straight septum.

Some of the more common nasal deformities resulting from this type of trauma are: External deviation of the nasal pyramid (Figs. 1 and 3), malunited bony spicules (Fig. 2), separation of the nasal bones in the midline with a broadening of the bridge of the nose, saddling deformities (Figs. 4 and 5), and hump formation (Figs. 6, 7 and 8). In



Fig. 3. Preoperative and postoperative views; Case C.B.
History: Nasal trauma; difficulty breathing through right nostril.
Examination: Marked external deviation to the right. Large nose with drooping tip, septal dislocation to the right and deviation to the left. Asymmetry of top.
Procedure: Septal reconstruction, osteotomies and infracture, tip reconstruction.

attempting a correction of these deformities, the first prerequisite is a careful analysis of all aspects of the nasal deformity. This can be accomplished by careful visual examination, palpation and analysis of preoperative photographs taken in standard views, illustrating the front view, base view, and profile view, both smiling and sober. From photographs it is possible for the surgeon to sketch in the desired changes, taking into consideration both his own concepts of a normal appearing nose and its relationship to the other facial features as well as the desires of the individual patient. He

can then form an opinion as to the degree of deviation from the midline position, amount of hump to be removed, extent to which a saddling deformity should be built up, etc.

Almost invariably in these cases, a complete rhinoplasty is indicated—freeing up each individual



Fig. 4. Preoperative and postoperative views; Case J.B.
History: Nasal injury as a child. Submucous resection at age 16 with subsequent broadening of nose and difficulty breathing.
Examination: Broad, flat nose, small bony hump, saddling of cartilage dorsum, asymmetry of tip and nostril, retracted columella, residual septal deflection.
Procedure: Septal reconstruction, hump removal osteotomies, upper lateral cartilages freed up from septum, tip reconstruction and use of Silastic implant in dorsum.



Fig. 5. Preoperative and postoperative views; Case C.K.

History: Nasal trauma and previous nasal surgery followed by hemorrhage with resultant nasal deformity and difficulty breathing through the left nostril.

Examination: Marked deformity of nose with complete asymmetry of bony, upper lateral and tip elements. Marked nasal hump, severe cartilaginous saddling, retracted columella, septum deviated to the left, asymmetry of alae.

Procedure: Septum exposed and found to have had previous submucous resection with a dislocated vomer present: this was returned to the midline position. Hump was removed, osteotomies and infracture performed, upper lateral cartilages realigned and sutured together in midline, tip reconstruction, saddle deformity corrected by use of excised cartilage and bone.



Fig. 6. Preoperative and postoperative views; Case B.K.

History: Some difficulty breathing, post-nasal discharge and hump deformity.

Examination: Large nose with bony and cartilaginous hump. Web formation at base of columella.

Procedure: Removal of anterior nasal spine, septal reconstruction, hump removal, osteotomies, tip reconstruction.



Fig. 7. Preoperative and postoperative views: Case B.K.

Examination: Bony and cartilaginous hump, drooping tip and hanging columella.

Procedure: Hump removal, osteotomies and infracture, septal reconstruction, tip reconstruction.

component, namely the nasal bones, the upper lateral cartilages and the alar cartilages, after which they may be repositioned to obtain the desired functional and cosmetic result.

B. PRENATAL AND CHILDHOOD TRAUMA

As in adults, nasal trauma in children is extremely common, but frequently it is of a more minor



Fig. 8. Preoperative and postoperative views; Case R.B.

History: Difficulty breathing through left nostril, possible nasal trauma.

Examination: Prominent bony and cartilaginous hump, drooping tip, asymmetry of tip and columella, septum markedly deviated to the left, receding chin.

Procedure: Hump, removal, osteotomies and infracture, upper lateral cartilages freed from septum. septal reconstruction, tip reconstruction, insertion of chin implant.

nature and is often overlooked, due to the smaller size of structures involved and to the difficulty of performing an adequate examination. As the child grows, these deformities will become magnified or lead to an arrest of the growth process of the individual structures which in turn leads to pronounced defects.[6] When these become apparent, it may be extremely difficult to elicit a specific history of the original trauma, either because it was of such a minor nature or because the parents have forgotten the incident and have neglected to report it to the child.

In the prenatal period, displacement of the nose or septum may occur as a result of forces acting on the nose during the latter months of intra-uterine life. During labor, injuries may occur as a result of improperly applied forceps blades or other manipulations.[7] In these cases, there may be a lateral displacement of the nose or of the septum or both. Many such traumata are confined to the cartilaginous structures. Some of these dislocations return to their normal position without manipulation but others may have to be rocked into place with a minimum of trauma or surgical intervention.



Fig. 9. Preoperative and postoperative views; Case H.I.

History: Nasal trauma with difficulty breathing.

Examination: Broad, flat nose with relative saddling of the dorsum, drooping tip, wide, flaring alae with large horizontal nostrils, receding chin.

Procedure: Osteotomies, tip reconstruction, insertion of dorsal Silastic implant and of Silastic columellar strut, narrowing of alae, insertion of chin implant.

* * *

DURING INFANCY and childhood, the nose continues to bear the brunt of multiple minor injuries. Most of these do not result in any visible deformity; there may only be occasional epistaxis or edema, but all play their role in the ultimate configuration and function of the nose. X-rays are seldom reliable in these cases, especially in children. Furthermore, some types of nasal trauma may lead to septal hematoma or septal abscess with necrosis of the cartilage. These cases require early incision and drainage. If left untreated, this results in a flattening or saddling of the cartilaginous vault and widening of the base of the lobule (Figs. 9, 10, 11 and 12).

Where marked septal deviations are present in childhood with gross obstruction of the airway, correction should be made.[8] Routine submucous resection, however, is absolutely contraindicated. The procedure of choice is a realignment of the dislocated or deviated septal cartilage to its normal position. By far the majority of these septal deflections involve only the cartilaginous portion and it is therefore not necessary to manipulate the bony septum. In carefully controlled groups of cases with long periods of follow-up, it has been shown that conservative surgical intervention, as outlined above, does not result in arrest of the growth factors and in fact, by providing the natural stimulus of breathing through the nose, results in a more normal appearing nose later in life.

Where a saddling of the dorsum has occurred during childhood and a psychological problem evolves, the deformity may be corrected by inserting implants of a progressively larger size.

C. IATROGENIC

Here we are referring specifically to the late sequelae of a too radical resection of the bony and cartilaginous components of the nasal septum.

In routine submucous resections, a large part of the septal cartilage is removed, leaving only a narrow strip of cartilage superiorly along the vault and usually, but not always, a strip along the caudal border. These strips are left because the physician realizes that without them the nose has inadequate support and may collapse. These patients inevitably have an uneventful postoperative course and obtain an adequate airway. They are seen by the surgeon during the first few weeks postoperatively, and then the patient is usually on his own. The deformities resulting from this type of submucous resection usually do not occur within the first few weeks postoperatively and may not become apparent until several months have elapsed. With each succeeding year, however, they become more noticeable. Due to the gradual change, the



Fig. 10. Preoperative and postoperative views; Case D.H.
History: Nasal fracture at age 2½ with subsequent hemotoma and abscess formation.
Examination: Severe dorsal saddling, flat, broad tip with no septal support, retracted columella with scar, receding chin.
Procedure: Tip reconstruction and insertion of Silastic columellar strut, insertion of large dorsal Silastic implant and of chin implant.
Figure on far right (side views) illustrates x-ray view of Silastic implants.

patient may not relate his problem directly to the preceding surgery and therefore, the original physician may not be consulted again. Many of these changes are not gross enough to be apparent immediately to the physician but they may nevertheless be of concern to the patient from both an aesthetic and a functional standpoint.

The typical changes are a mild depression or saddling of the middle one-third of the dorsum of the nose at the junction of the upper lateral cartilages and nasal bones (Figs. 2, 4 and 5). Associated with this change is a retraction of the columella and a drooping of the tip of the nose; the tip becomes more rounded and broader. On palpation the tip of the nose is devoid of support. Many of these patients will complain of difficulty in breathing and will state that they have lost the original improvement in airway, which was obtained following submucous resection. The mechanics of this can easily be demonstrated by elevating the nasal tip—the patient notices an immediate improvement in breathing ability.

* * *

IN SOME CASES, these deformities are undoubtedly due to lack of adequate support, but in

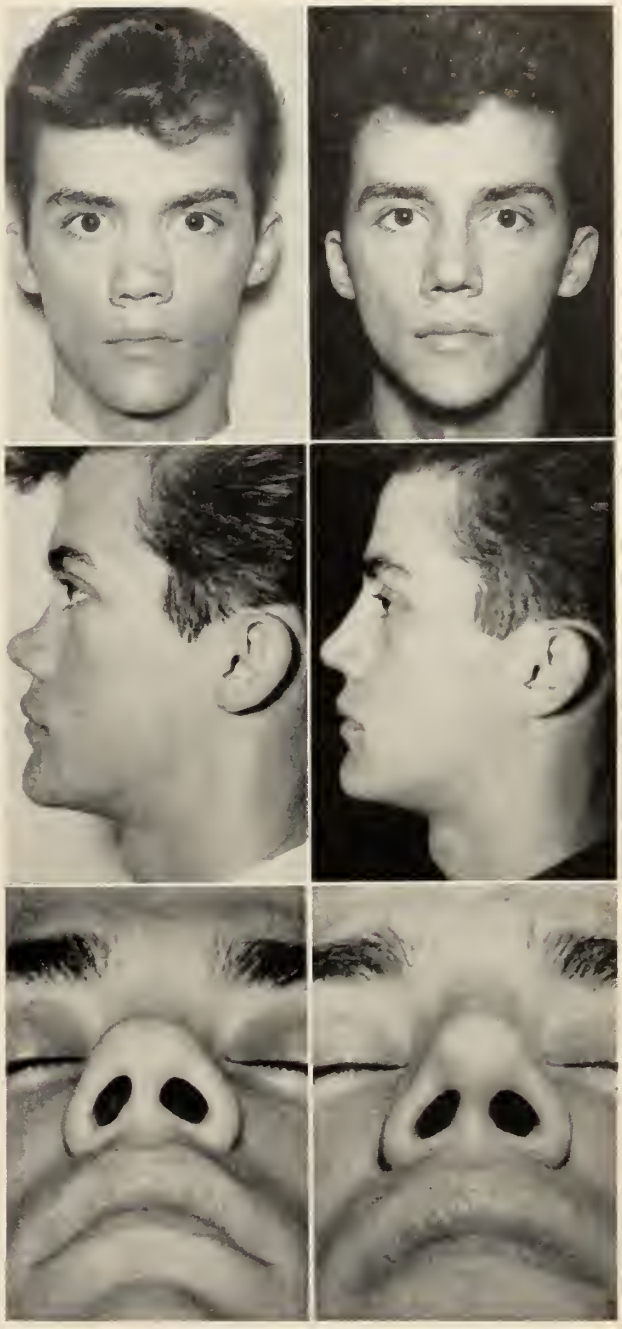


Fig. 11. Preoperative and postoperative views; Case R.S.
History: Nasal fracture at age 11.
Examination: Asymmetry of nose and tip, severe dorsal saddling, broad, flat tip with retracted columella and little septal support. Marked septal deviation to the left.
Procedure: Septal reconstruction, tip reconstruction and insertion of dorsal Silastic implant.

others, an additional factor may be responsible: this may be the internal traction forces of healing of de-skeletonized membranes. As scar tissue contraction of the septum occurs, the results show up in the weak areas; the columella and middle-cartilage vault.

The minor deformities may be corrected by reconstruction of the alar cartilages so that they



Fig 12. Preoperative and postoperative views; Case M.U.
History: Harelip, nasal trauma.
Examination: Nasal deviation and saddling of dorsum, asymmetry of tip due to trauma and previous harelip correction.
Procedure: Osteotomies, tip reconstruction, insertion of dorsal Silastic implant and revision of harelip scar.

rotate upward thereby elevating the tip and filling in the saddled area.

Due to complete lack of support, most cases will require a graft or implant in addition to a tip reconstruction. Usually osteotomies and infracture of the nasal bones must also be carried out.

The favored grafting materials are costal cartilage and iliac bone. Both, however, have distinct disadvantages. Costal cartilage has a tendency to warp and curl. Iliac bone requires an additional surgical procedure and there is a high rate of absorption and/or extrusion.

Most of the alloplastic implants have not been very successful. Recently, however, with the advent of the silicone rubber compounds and their successful use in many areas of the body, we have used this material in nasal reconstructive surgery. Our initial results with Silastic have been extremely encouraging.[9] The material is well-tolerated, shows no foreign body reaction and is seldom extruded (Figs. 4, 9, 10, 11 and 12).

SUMMARY

In evaluating nasal dysfunction and nasal appearance, it is important to consider all physiological and anatomical aspects of the nose—both the external nose and the septum. The rhinologic surgeon should correct both deformities of the nasal septum and the external nose as a unit. Conservative surgery of the septum is of utmost importance.

Causes of naso-septal deformities are: hereditary factors, racial factors and trauma. Traumatic factors have been divided into: (A) major trauma of adulthood, (B) minor trauma of infancy and childhood affecting the growth process of the nose and (C) iatrogenic, due to radical resection of septal support during submucous resection.

The correction of the resulting deformities has been briefly outlined. We have found Silastic of great help in the correction of saddle deformities.

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Michigan Well Represented At Medical Assistants Convention

A sizeable delegation of MSMAS members participated in the American Association of Medical Assistants Convention in Oklahoma City. MSMAS President Phyllis Marquardt, Kalamazoo, reports that "all the girls from Michigan were dressed in white sharkskin shifts with sailor collars trimmed in red, white and blue braid. White sailor hats featured a red hat band with Michigan printed on it!"

The Michigan delegation entertained the AAMA members at a Michigan Outdoor Party, serving wieners, cider and potato chips.

Mrs. Betty Lou Willey, St. Clair, was chairman of the Reference Committee on Constitution and Bylaws. Mrs. Reta Stahl, Albion, continues on the AAMA Board of Trustees, and Glen E. Millard, M.D., Detroit, as a member of the AAMA Advisory Committee.

Attending the meeting were Miss Marquardt, Mrs. Juanita Ferman, MSMAS President-Elect, Jackson; Mrs. Dorothy Brandis, Past President, Ingham; Mrs. Willey; Miss Marie Weatherwax, Treasurer, Washtenaw; Mrs. Stahl; Miss Cecile Rutan, Jackson; Miss Donna Hislop, Muskegon; Mrs. Dolores Kobylka, Detroit; Mrs. Betty Attaway and Miss Ilah Schroyer, both of Flint; Mrs. Lenora Puschel, Kalamazoo; Miss Jeanne O'Toole and Louise Murray, both of Muskegon; Helen Ford and Peggy Woody, both of Oakland; Mrs. Eileen Wyatt, Bay City; Doctor and Mrs. Millard, Mr. Ferman, and Miss Helen Schick, of Blue Shield, an honorary member.

TABLE I. MICHIGAN LEUKEMIA DEATHS BY CELLULAR TYPE 1950-1961

Cellular Type	Number of Leukemia Deaths	Proportion of Total Deaths from Leukemia
Lymphatic	1,667	31.0%
Myeloid	1,271	23.6%
Monocytic	561	10.4%
Other and Unspecified	1,887	35.0%
All Types	5,386	100.0%

By DONALD C. SMITH, M.D., LOIS K. RUPKE, R.N., AND WILLIAM J. DEWEY, M.S., Ann Arbor

EPIDEMIOLOGY OF LEUKEMIA MORTALITY IN MICHIGAN, 1950-1960

The apparent increase in leukemia as a cause of death has been of considerable interest to practicing physicians in recent years. The relatively few epidemiological studies which have been carried out in various parts of the world have strengthened the impression that this fatal disease has grown more prevalent. A number of causal factors have been postulated, but as yet no specific etiological agents have been identified. It is difficult to assess how much of the apparent increase in incidence is genuine, and how much is due to the development of improved diagnostic techniques, to the increasing availability of medical facilities, and to changing characteristics of the population.

Our interest in the extent and distribution of this problem in Michigan developed from participation in the National Cooperative Leukemia Study, a project sponsored by the National Cancer Institute in which some 15 medical centers across the country participated. Final analysis of the pooled data from this cooperative study is not yet complete. In the meantime, it was decided to examine in more detail the leukemia mortality data in the State of Michigan for the period from 1950-1961.

The Michigan data were obtained from three main sources:

1. The annual statistical reports of the Michigan Department of Health.
2. An individual review of the death certificates filed on all Michigan residents who died from leukemia during the calendar years 1959, 1960, and 1961.
3. The National Office of Vital Statistics.

This paper will concern itself with the distribution of leukemia mortality by clinical and cellular type, geographic distribution, age, sex, race, urbanization, and temporal-spacial relationships, and will consider time trends in leukemia mortality.

DISTRIBUTION OF LEUKEMIA BY CELLULAR TYPE AND DURATION OF ILLNESS

Leukemia, as a generic term, applies to a group of diseases characterized by abnormal and excessively rapid reproduction of the leukopoietic tissues throughout the body. These diseases are commonly classified according to the type of cell undergoing abnormal change, i.e., lymphatic, myeloid and monocytic. They are further differentiated as acute or chronic, depending upon the duration of the illness. Some authorities regard acute leukemia as a distinct entity,[1] whereas others consider it to be only a more rapidly developing variety of the disease.[2]

In Table I are presented Michigan data concerning the distribution of leukemia mortality by cellular types, as recorded, for the years 1950 through 1961. As might be expected, these data lack specificity, some 35 per cent of cases falling in the "Other and Unspecified" category. Approximately



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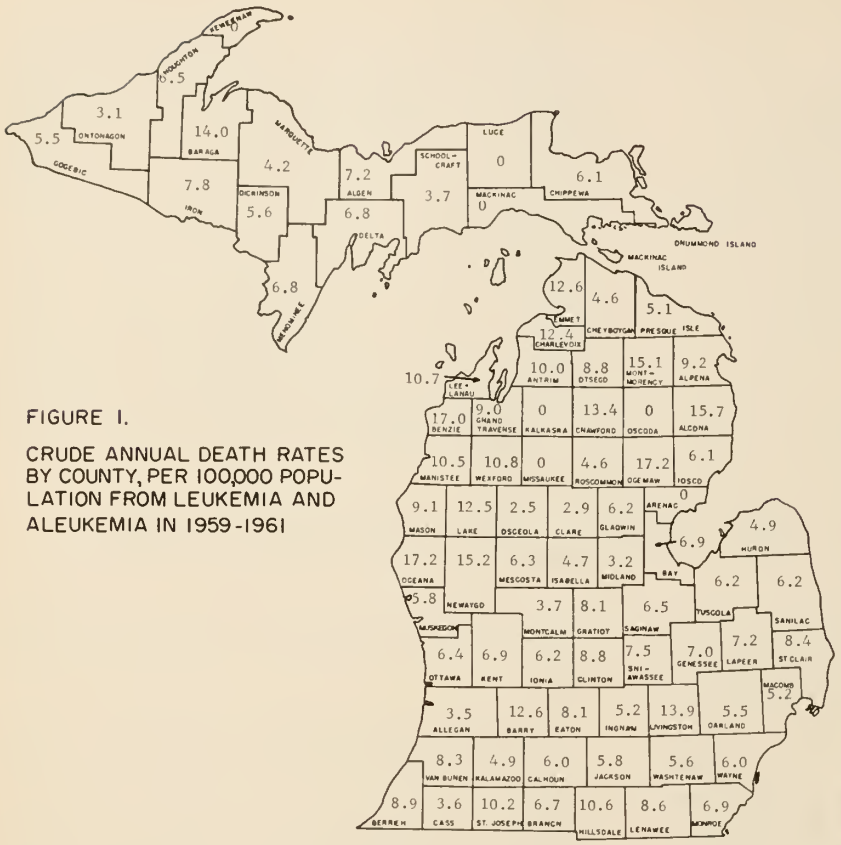


FIGURE 1.

CRUDE ANNUAL DEATH RATES BY COUNTY, PER 100,000 POPULATION FROM LEUKEMIA AND ALEUKEMIA IN 1959-1961

Abstract

Recent studies in several parts of the world, including Michigan, show a rapidly increasing death rate from leukemia, and striking variation in the incidence of this disease among different age groups. Differences between the sexes, between urban and rural populations, and between Negroes and whites, are also seen. In some respects, the picture in Michigan is similar to that seen elsewhere, but some of the usual differences disappear or are reversed in the Michigan findings.

one-third of the leukemia deaths in this period were designated as lymphatic and one quarter as myeloid.

GEOGRAPHIC DISTRIBUTION OF LEUKEMIA IN MICHIGAN

The geographic variations in leukemia mortality within the state of Michigan have been determined by examination of the 1,487 death certificates recording leukemia as the cause of death during the year 1959, 1960, and 1961. The overall state rate was 6.3 per 100,000 population. Figure 1 shows the county-by-county crude annual death rates per 100,000 population for leukemia and aleukemia for the period of 1959-1961. Interesting variations between rates for the individual counties can be seen, but statistical tests fail to demonstrate that these differences are significant. It is possible that real differences could be shown to exist if these data were collected over a longer period of time; it must be borne in mind that the actual number of cases of leukemia in most counties in any three-year period is small.

DISTRIBUTION OF LEUKEMIA MORTALITY BY AGE IN MICHIGAN

The age specific death rates for leukemia in Michigan for the years 1940, 1950, and 1960, are shown graphically in Figure 2. The peaks in mortality in the under 5 and over 65 age groups are apparent. Up to the age of 60 years, there has been little rise in rates in any age group. However, over 60 years of age, the rates have increased sharply between 1940-1950, and again, between 1950-1960.

The extent to which leukemia deaths in persons over 50 years of age contribute to the total picture of mortality from the disease is shown in Table II. In the twenty-year period 1940-1960, the leukemia death rates among all persons over 50 has almost doubled.

DISTRIBUTION OF LEUKEMIA BY SEX AND RACE

It has generally been observed that the incidence of leukemia among males is greater than among

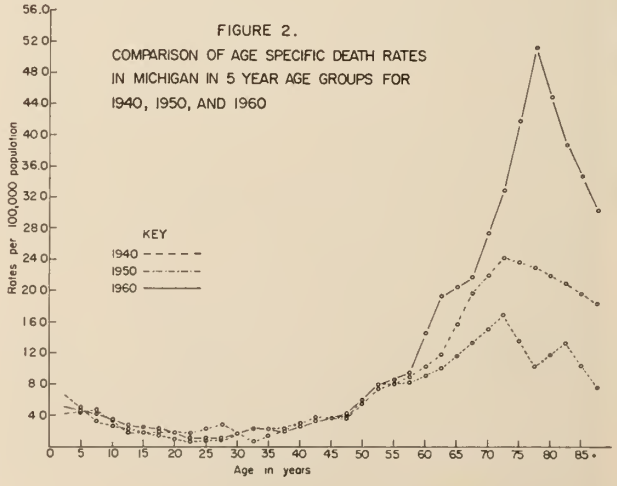


TABLE II. MICHIGAN LEUKEMIA DEATHS IN PERSONS OVER 50, 1940-1960

Year	% of Michigan Persons Over 50 Years of Age	% of Total Deaths from Leukemia Occurring in the Over 50 Year Group	Leukemia Death Rate Per 100,000 Persons in the Group Over 50
1940	19.8%	49.3%	10.2
1950	21.6%	57.3%	13.4
1960	21.5%	62.6%	19.5

females. Several authors have observed an overall proportion of about 60 per cent of leukemia deaths occurring in males.[3,4,5]

The reported mortality from leukemia differs among races and ethnic groups. The white population of the United States is affected at a considerably greater rate than the non-white population;[4] however, the increase in mortality attributed to leukemia has been greater among non-whites than among whites.[6] Standardization to allow for differences in age distribution between the white and Negro populations decreases but does not eliminate the difference in leukemia death rates.[7]

In Michigan, leukemia mortality among white persons has been significantly lower, and among non-whites significantly higher, than the national average experience for each group.

It has been found that leukemia is recorded as a cause of death twice as frequently among Jews as among others. This relationship is seen at all ages, in both sexes, in all the usual pathologic types of leukemia, and in both native-born and foreign-born populations.[8]

The Michigan data shown in Table III agree with the higher death rate generally observed for males and the higher rate among whites than non-whites.

URBAN-RURAL DISTRIBUTION OF LEUKEMIA

It has been observed in the United States[9] and elsewhere[10,11] that there appears to be a greater reported incidence of leukemia among residents of urban localities than among those in rural areas. Considering that these differences are highly age specific, it seems unlikely that the higher crude rates in urban populations can be accounted for by superior diagnostic services available in cities.

In Michigan, for the years 1959-1961, however, the generally observed trend toward higher urban leukemia incidence rates is reversed. This was established by two comparisons:

1. The leukemia death rate observed in the nine metropolitan counties of the state (Genesee, Ingham, Kalamazoo, Kent, Macomb, Muskegon, Oakland, Saginaw, and Wayne) was compared with the rate computed for the other 74 counties (Table IV).

TABLE IV. MICHIGAN LEUKEMIA MORTALITY BY METROPOLITAN VS. NON-METROPOLITAN COUNTIES

Area	Leukemia Mortality Rate Per 100,000 Population
State Average	6.3
Metropolitan Counties (Genesee, Ingham, Kalamazoo, Kent, Macomb, Muskegon, Oakland, Saginaw, Wayne)	5.9
Non-Metropolitan Counties	7.2

2. The leukemia death rate observed in areas having a population of 2,500 or more was compared with those observed in areas having a population of less than 2,500 (Table V).

TABLE V. MICHIGAN LEUKEMIA MORTALITY BY PLACE OF RESIDENCE

Area	Leukemia Mortality Rate per 100,000 Population
State Average	6.3
Areas of 2,500 or more population	5.7
Areas less than 2,500 population	8.0

TEMPORAL-SPATIAL RELATIONSHIPS

Several studies have produced evidence suggestive of residential aggregation in the distribution of childhood leukemia.[12,13] Recently, nationwide attention has been drawn to this clustering by a report concerning an unusual number of cases of acute leukemia in children in Niles, Illinois.[14] This town of some 20,000 inhabitants had an occurrence of eight cases, of which seven were girls, aged 3-14, between September 1957 and August 1960, giving an incidence 20 times the national rate. All the cases were lymphoblastic leukemia; all the children had moved recently to the suburb from Chicago; and all had been attending the same parish school or had older siblings or a friend in the school. Further studies of this "outbreak," which is similar

TABLE III. MICHIGAN LEUKEMIA DEATH RATES BY AGE AND SEX (per 100,000)

Period	White			Non-White			Total		
	Male	Female	Both	Male	Female	Both	Male	Female	Both
1949-51	6.2	4.3	5.2	6.3	2.4	4.6	6.2	4.2	5.2
1959-61	7.9	5.8	6.7	4.3	2.3	3.3	7.6	5.1	6.3

TABLE VI. "OUTBREAKS" OF LEUKEMIA IN MICHIGAN
1959-61

Town	County	Three-year Population	Leukemia Deaths	Leukemia Death Rate Per 100,000 Population
Petoskey	Emmet	19,404	3	15.0
Hastings	Barry	18,288	3	16.4
St. Louis	Gratiot	10,041	3	29.8
Portland	Ionia	6,421	3	55.6
Fremont	Newago	9,168	5	54.5
Niles	Berrien	11,526	7	60.7

in nature to that of an infectious disease, are in progress and should be of considerable interest.

In an attempt to discover if there might be any areas within the State of Michigan with an excessive number of deaths from leukemia during this three-year period, the 1,487 deaths were plotted on individual county maps. Data for six selected communities are given in Table VI. As in the case of the county-rate differences, these variations do not possess statistical significance.

TRENDS IN LEUKEMIA MORTALITY

In any attempt to analyze studies dealing with trends in leukemia mortality, certain considerations must be borne in mind. One is that the accuracy of mortality statistics depends upon the accuracy of the medical certification of deaths. Another is the changes in the age distribution of a population as they may affect the crude death rates of a disease influenced by age.

A number of studies, both in this country and abroad, have found that leukemia death rates have increased by approximately 50 per cent per decade since 1920. Where they have been studied, age-specific mortality rates have also shown significant increases. These studies have dealt with the problem of leukemia not only in the United States,[4,5] but in Canada,[16] Australia,[17] Japan,[18] and a number of countries in Western Europe.[19,20,21]

TABLE VII. CRUDE PREVALENCE AND INCIDENCE OF LEUKEMIA AND ALEUKEMIA IN MICHIGAN
1940-1960

Year	Number of Deaths	Rate per 100,000 General Population
1960	516	6.6
1959	475	6.0
1958	526	6.7
1957	435	6.2
1956	471	6.3
1955	444	6.1
1954	435	6.2
1953	425	6.2
1952	403	6.0
1951	369	5.6
1950	321	5.0
1949	332	5.2
1948	296	4.8
1947	299	4.9
1946	295	5.2
1945	255	4.7
1944	230	4.3
1943	230	4.3
1942	212	3.8
1941	217	4.0
1940	215	4.2

In the State of Michigan, there has been a steady increase in both the number of deaths from leukemia and in the crude death rates throughout the period 1940-60. As is shown in Table VII, the leukemia mortality rate has increased from 4.2 deaths per 100,000 population in 1940, to 6.6 deaths per 100,000 population in 1960. As was mentioned previously at least part of the increase in the crude death rate is due to increasing age specific death rates in the older age groups.

SUMMARY AND CONCLUSIONS

An examination of leukemia mortality data recorded in the State of Michigan during the period 1950-1961, has been presented and compared with other findings available in the recent literature. The following points have been noted:

1. Leukemia is a uniformly fatal disease which can occur at any age. The highest age-specific death rates and by far the greatest number of deaths from leukemia are found in the under 5 and over 65-year age groups.

2. In children, leukemia is almost always acute and usually classified as being lymphoblastic or "stem-cell" in type. Young adults and middle-aged persons are affected by lymphatic and myeloid leukemia in about equal rates. Lymphatic leukemia seems to increase during the forties and fifties and at ages over 70 it again becomes the most common type.

3. It is generally observed that the incidence of leukemia is approximately ⅓ higher in males than in females. This sex difference is most marked in lymphatic leukemia and in the pre-school and late adolescent age groups.

4. Increasing leukemia mortality rates have been demonstrated for a number of countries. These increases are most marked in children in the 2-4 and 15-19 year age groups, and in persons over 65 years of age.

5. Variations in the occurrence of this disease have been observed between countries and between urban and rural communities. Geographic variations in leukemia mortality are most marked in the over 65-year age segment of the population.

They may be associated with differences in exposure to infectious disease or to differences in the

availability of medical care, but neither relationship can be clearly expressed. Regional variations in leukemia mortality within a country and differences in urban and rural mortality rates may also be related to the availability of medical care and particularly to the adequacy of diagnostic facilities. Population density is, however, a factor which deserves further examination.

In Michigan, a moderate and non-significant reversal of the usual urban-rural difference has been observed. Most studies have found a somewhat increased incidence in leukemia as a certified cause of death among urban populations, but in Michigan the incidence is somewhat higher among rural populations. Part of this difference can be accounted for by the concentration of negroes in the urban areas.

6. There are demonstrable differences in leukemia mortality between the white and non-white populations, less striking in Michigan than elsewhere.

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State Describes Cases In Poison Control Centers

The Michigan Department of Health reports the Poison Control Centers in 21 cities continue to handle an increasing volume of requests for assistance and information.

A report from the National Clearing House for Poison Control Centers reveals that during the calendar year 1963, there was a total of 3,334 cases of ingestion of toxic substances reported to Michigan centers, involving some 86 different substances.

As usual, aspirin remains the number one culprit in poisonings. There were 374 cases involving baby aspirin, 96 cases involving adult-type aspirin, 313 involving unspecified type of aspirin, and another 80 cases involving other analgesic substances.

The second leading cause of poisoning, according to the State Health Department, was barbiturates, with 152 cases, followed by bleaches, 123; soaps and detergents, 104; and insecticides, 95.

The vast majority of cases—2,615 of the 3,334—involved youngsters under five. The most vulnerable group are the two-year-olds, 1,040; next are the one-year-olds, 731; followed by the three-year-olds, 530; the four-year-olds, 168; and those under one year, 106. In each age group, there were more boys affected than girls.

Seasonally, the months from July to September were the most hazardous by a considerable margin, accounting for 1,112 cases while the winter months of January through March were safest with only 659 cases reported. From October through December there were 845 cases compared to 718 cases reported from April through June.

Poison control centers are located in Michigan in Adrian, Ann Arbor, Bad Axe, Battle Creek, Bay City, Coldwater, Detroit, Flint, Grand Rapids, Kalamazoo, Lincoln Park, Midland, Petoskey, Pontiac, Port Huron, and Saginaw; poison treatment centers are located in Bay City, Detroit, Jackson, Lansing, Wayne, and Ypsilanti; and poison information centers are located in Detroit and Marquette.

Therapy for the hemophilic patient is dependent upon both local and systemic measures. Application of cold and pressure often provide adequate control for local bleeding problems. In the event of severe bleeding into vital structures, systemic therapy in the form of plasma or plasma fractions must be employed.

The classical hemophilic disorder with decreased antihemophilic factor activity (AHG) will respond to fresh or fresh-frozen plasma or to concentrates of AHG prepared from plasma. The latter preparation is available without cost from the State laboratories and is seven times more potent than an equivalent weight of plasma, although of equal activity by volume.

Hemophilia B or Christmas disease will respond to stored refrigerated plasma as well as fresh plasma.

Fresh or fresh-frozen plasma should always be employed whenever the type of hemophilia is unknown or in doubt.

Therapy
For the Hemophilic Patient

By JOHN A. PENNER, M.D.
Ann Arbor

INTRODUCTION

Effective management of hemorrhage in the hemophilic patient requires that the physician be experienced in the treatment of these disorders and have some knowledge of coagulation techniques and theory. Large medical centers such as The University of Michigan Medical Center through the Simpson Memorial Institute can provide ideal laboratory support and clinical consultation for these patients. However, as often occurs, the hemophilic patient develops severe bleeding which demands immediate attention. In such instances, the family physician must be prepared to manage the acute bleeding episodes.

Despite the lack of special laboratory facilities, it is possible to treat these patients adequately in a general hospital, providing the physician has a knowledge of the products available for therapy and the therapeutic requirements of the condition.

The following outline was prepared to provide the family physician with information on basic concepts of therapy in these disorders and to inform him of the products available for therapy. This paper is not intended to present a complete or final discussion of hemophilia and should be used only as a guide. A more extensive coverage of this subject can be found in the appended reference list.



Author
JOHN A. PENNER
M.D.

THERAPY

Hemophilia represents a group of familial bleeding disorders characterized by deficiencies of specific clotting factors. This lack of activity may be a result of inadequate production or of binding of a factor by a very specific and potent inhibitor. Several types of hemophilia can be differentiated. Hemophilia A or classical hemophilia exhibits a deficiency of a plasma factor activity, antihemophilic globulin (AHG, Factor VIII). Hemophilia B or Christmas disease lacks a serum factor activity, plasma thromboplastin component (PTC, Factor IX). Other rare forms of hemophilia-like disorders have been described. In all of these conditions,

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This work was supported by the Michigan Heart Association and the Michigan Hemophilia Foundation.

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therapy includes the use of plasma products capable of increasing the circulating level of the deficient factor or its precursors.

PROPERTIES OF ANTI-HEMOPHILIC GLOBULIN (AHG)

AHG is a plasma protein known for its coagulant activity and its labile nature. Its activity diminishes rapidly within hours when stored at room or refrigerator temperatures. This factor has not been prepared in pure form. Concentrates, however, have been produced by plasma fractionation procedures.

Metabolism: In the circulation, AHG appears to have a half-life of approximately 24 hours. After administration AHG rapidly diffuses out of the blood stream into the extravascular fluids. This results in a sharp decrease in the circulating level of this factor within six hours. A more gradual rate of disappearance is noted after an equilibrium is established.

Activity: AHG is a procoagulant that appears to act as a co-factor for one of platelet substances (platelet factor 3). In the presence of platelets and a third factor PTC (Christmas factor, Factor IX) it initiates prothrombin activation to thrombin. Thrombin in turn will act on fibrinogen to produce a fibrin clot. A simplified scheme is shown as follows:

Platelet factor

AHG (VIII)
PTC (IX)
Ca^{++}
accelerator factors (V & X)

Prothrombin ——————→ Thrombin

(Thromboplastin from tissues has an activity similar to the combined platelet factor-AHG - PTC complex shown. Consequently if tissue products are permitted to enter a hemophilic blood specimen, the deficiency may be masked. Clotting tests in such instances may appear normal.)

PREPARATIONS CONTAINING AHG

Plasma: Fresh plasma drawn within six hours of use will contain AHG in variable concentration depending on the donor's circulating level. A range of 60 to 160 per cent has been found in supposed normal donors using pooled fresh plasma as 100 per cent. (Crossmatching is required when unpooled plasma is employed in treatment.)

Frozen Plasma: Plasma frozen immediately after it is obtained will retain AHG activity for weeks to months depending on the temperature of storage. The usual blood bank freezers probably cannot be relied upon to preserve full AHG activity for more than a few months. (Crossmatching is required for frozen plasma when unpooled products are used.)

Dried Plasma: (Hyland Laboratories, California. Michael Reese, Chicago 250 ml. bottle*). Plasma is pooled first and then dried from the frozen state. It contains 50 to 80 per cent of normal concentration of AHG activity and is stable at refrigerator temperatures. (Pooled plasma may be associated with a higher incidence of hepatitis. Its use does not require crossmatching.)

"Anti-Hemophilic Globulin"†: (Michigan Department of Health Laboratories, Fraction I,—provided without cost to Michigan residents, 500 mg./50 ml. bottle.) This product is prepared by fractionation of fresh plasma. It contains considerable fibrinogen and other proteins. The product is treated with ultraviolet irradiation to reduce the risk of hepatitis. (Hepatitis has not been encountered following the use of this material during the 14 years of its production; crossmatching is not required.)

"Fibrinogen—AHG"†: (Merck Sharp and Dohme, Fraction I, 2 gm./200 ml. bottle.**) This product is prepared by fractionation of fresh plasma and appears similar to the Michigan Department of Health preparation.

CLINICAL MANIFESTATIONS

Bleeding in the hemophilic individual is variable and episodic. Some patients may not exhibit signs of hemorrhage for years and then develop multiple episodes during a several month period. Exacerbation of the condition has not been definitely associated with diet, bacterial infection or stress. Acute viral infections are suspect, however.

Bleeding commonly involves joints, muscles, kidneys, the gastrointestinal tract, nasopharynx and retroperitoneal areas. Hemorrhage will occur after minor trauma or may appear spontaneously. Frequent trauma with bleeding into a single area may produce a pseudotumor containing old blood, necrotic and fibrous tissue and bone. These tumors may be mistaken for osteogenic sarcoma on roentgenographic examination.

INDICATION FOR THERAPY

The patient's past experience is important. If adequate therapy is initiated at the first sign of bleeding, it may be possible to prevent further bleeding and reduce the period of hospitalization. In general, it would seem that a *spontaneous* hemorrhage often portends further bleeding and should be treated with systemic therapy. Traumatic hemorrhage when localized may not require

*Dried plasma products range in price from $20 to $35 per bottle.

†This product when reconstituted according to the manufacturers specifications will yield solutions containing approximately the same concentration of AHG per ml. as fresh normal plasma. The total protein content of the dried concentrates, however, is seven times less than in a comparable amount of plasma, in consequence of which a much larger quantity of this product may be tolerated by the patient.

**Approximate blood bank cost $35 per bottle.

systemic measures. Sublingual hemorrhage, urinary tract and gastrointestinal bleeding are always of a serious nature and should be treated immediately with ample quantities of plasma or antihemophilic globulin.

THERAPEUTIC REQUIREMENTS

In severe cases of hemophilia, AHG activity is virtually absent. A number of investigators believe that a level of 10 to 20 per cent of normal AHG activity is necessary for hemostasis. Given a patient with severe manifestations of the disorder (AHG activity less than 1 per cent and an estimated plasma volume of 2,000 ml., infusion of 240 ml. of normal plasma) would provide a minimum level of AHG activity. Diffusion and utilization, however, produce a rapid loss of activity and necessitate the use of much larger quantities of normal plasma or its equivalent to maintain AHG at an adequate level for a 24-hour period. As equilibrium is reached with the extravascular fluids, utilization becomes the primary factor affecting the AHG level. The suggested half-life of 24 hours would require replacement of one-half the AHG daily, providing large amounts are not lost into areas of hemorrhage. The possibility also exists that fluctuations may occur in the production of an inhibitor or of a complexing substance which would modify AHG requirements during therapy.

THERAPEUTIC EQUIVALENTS

	Volume	*Dry Wt.*	*Plasma Equiv. (approx.)*
Plasma (fresh, fresh-frozen, dried)	200 ml.	12.0 gms.	200 ml.
"AHG" (Mich. Dept. Health)	50 ml.	0.5 gms.	50 ml.
"Fibrinogen - AHG" (Merck)	200 ml.	2.0 gms.	200 ml.

PROGRAM OF THERAPY

Local treatment includes the application of pressure over the bleeding site and the use of cold or other local vasoconstrictor to reduce blood flow. Elastic bandages if applied early will reduce bleeding into an injured area. Packing of open wounds with gelfoam or similar materials soaked in thrombin* is helpful. Root canals should be packed after dental extraction and sutures placed if necessary to retain the packing. An acrylic splint or saline-soaked gauze will allow the patient to exert pressure on the gelfoam pack by biting down over the extraction site. Ischemia of the area and consequent necrosis will occur, however, if pressure is maintained for too long a period.

Systemic therapy involves intravenous infusion of AHG-rich preparations. At present, hemostasis can be achieved in the hemophiliac with serious bleeding only when the circulating level of AHG has been increased. In order to reach effective levels, *large quantities of AHG concentrate or plasma must be given within a short period of time. Smaller quantities given intermittently will not control bleeding.*

An adult patient will require at least 500 ml. of plasma or concentrated AHG initially. If considerable blood loss has occurred, the vascular bed will accept larger quantities of plasma. (Mild anemia, if asymptomatic, should be considered of secondary importance in this situation.) Overexpansion of the plasma volume should be considered as the potential major hazard of therapy. Most young adults, however, tolerate large transfusions of plasma without difficulty. Other complications include: *thrombocytopenia*, probably of an isoimmune type and *hemolytic anemia* secondary to isoantibodies present in the infused plasma or to hyperfibrinogenemia resulting from the use of AHG concentrates of Cohn fraction I type. Reactions to plasma and plasma fractions have been observed and include manifestations such as fever and chills, hives and pruritus. Hydrocortisone 50 mg. and Benadryl 50 mg. have been effective in controlling the symptoms and will in most cases permit the infusion to be continued at a much slower rate.

An initial dose of 500 ml. of plasma should be followed by 250 ml. at six-hour intervals. If bleeding is not controlled within the first 24 hours of therapy, plasma (250 ml.) should be administered every four hours. If the plasma is frozen, it should be thawed quickly and infused as soon as possible, at a rapid rate (15-20 minutes/unit).

AHG concentrates can be given in quantities similar to that employed for plasma and will offer a considerable advantage in that hemostasis can be improved with a smaller protein load and if necessary much larger doses may be administered. Dried plasma and plasma fractures should also be administered rapidly immediately after they are reconstituted; otherwise, much of the AHG activity will be lost.

In situations where a severe or massive hemorrhage has occurred, therapy should be continued for at least two to three days after bleeding has been controlled. In the case of surgery or dental extraction, a 12-day period of maintenance therapy may be necessary to prevent recurrent bleeding and to promote wound healing. Internal hemorrhage will require massive amounts of antihemophilic globulin necessitating the use of two or three liters of plasmas or its equivalent daily. A single plasma or AHG concentrate infusion may be sufficient to prevent further bleeding in a patient presenting with a localized area of spontaneous hemorrhage.

Children and infants require smaller quantities of

*Thrombin topical, Parke, Davis and Co.

these products in direct relationship to their weights (approximately 10-12 ml./lb./day).

Example Cases:

1. Twelve-year-old boy admitted with gross hematuria of two days duration.

Therapy: AHG 500 ml. (10 bottles, Mich. Dept. Health Lab.) followed by 250 ml. (five bottles) at six-hour intervals for two days.

Result: The urine cleared completely on the second day. Hematuria three months prior to the present episode, lasted four weeks as a result of inadequate therapy.

2. Infant, six months old (22 lbs.), admitted with large traumatic hematoma on the forehead.

Therapy: AHG 50 ml. (1 bottle) every six hours for two days.

Result: Rapid disappearance of hematoma within three days.

3. Thirty-year-old man admitted following a dental extraction.

Therapy: Plasma 500 ml. followed by plasma 250 ml. every six hours.

Result: Bleeding recurred on fifth day when therapy was discontinued. Another six days of therapy controlled the bleeding and permitted wound healing to proceed normally.

PROPERTIES OF PLASMA THROMBOPLASTIN COMPONENT

(PTC, Factor IX)

PTC is a serum protein with coagulant activity. It is formed from a relatively stable precursor in plasma.

Metabolism: The precursor of PTC is produced in the liver. It requires vitamin K for synthesis and it may be reduced as a result of therapy with coumadin or related drugs. Deficiencies of this factor are also seen in association with hepatic disease and in the familial disorder Christmas disease. The half-life of the active serum form is short. The plasma precursor may circulate for 12 hours or more.

Activity: PTC is a serum procoagulant that acts in conjunction with a platelet factor and antihemophilic globulin to initiate prothrombin activation.

PREPARATIONS CONTAINING PTC

Plasma or whole blood stored for several weeks at refrigerator temperatures will retain most of its PTC (precursor) activity.

Fresh-frozen plasma may retain full PTC activity for periods up to a year.

Concentrates of PTC are not available.

CLINICAL MANIFESTATIONS

Occasionally, this disorder will appear in a mild form; however, the clinical manifestations are generally similar to those described for hemophilia A. The indications for therapy, requirements and program of therapy do not differ significantly from that of classical hemophilia.

Example Case:

1. Fifteen-year-old boy admitted with traumatic hemarthrosis.

Therapy: Plasma 500 ml. followed by plasma 200 ml. every six hours for three days. Local application of ice for the first 24 hours and an elastic bandage for one week.

Result: Rapid resolution of the hematoma with early weight bearing and full joint motion.

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MSMS Centennial Series: 1949, 1950

Honor U-M Medical School Centennial

Leading up to the MSMS Centennial in 1965, The Journal *is printing a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. This series began in the September, 1963, number of* The Journal *and will continue through August, 1965.*

—1949—

What a busy year Doctor Sladek had! I counted up my notes and there were 32 memos regarding the work of the Society for 1948-1949. We shall try to condense these:

The House of Delegates authorized the following:

1. That the income limits in the Michigan Medical Service policy be increased to $5,000;
2. That the fee schedules be increased approximately 40 per cent;
3. That MMS provide that all hospital services of physicians, both medical and surgical, be included as benefits;
4. That MMS continue all the present forms of contracts affecting the $2,500 income limits.

The MSMS Executive Committee, recognizing the need for an active Michigan Health Council, reaffirmed its contribution of $7,500.

The Membership of the MSMS was 4,960.

* * *

IMMUNIZATION Month was observed in May, with cooperation between practitioners and health departments to the end that Michigan children be immunized against smallpox, diphtheria, whooping cough, and tetanus.

The Michigan State Medical Assistants Society requested the appointment of an Advisory Committee, which was authorized.

A "Public Speaker's School for Doctors" was held September 22, Grand Rapids, at the time of the MSMS Annual Session.

A Public Relations brochure "The Country Doctor Answers the Ewing Report" has been mailed to each president of a Rotary Club in the U. S. with uniformly favorable reaction.

* * *

MSMS RECEIVED signal recognition at the AMA Atlantic City meeting in the publishing of lists of organizations which oppose socialized medicine—Michigan has twice as many organizations listed in this category as any other state.

The Council in September had a preview of a new MSMS movie "To Your Health."

MSMS thanked the Michigan Heart Association for its contribution of $32,515.72 and the Michigan Society for Crippled Children and Afflicted Adults for its contribution of $6,000 for continuation of the Michigan Rheumatic Fever Control Program. The second Heart and Rheumatic Fever Day was authorized for March 11, 1950.

An analysis of the Fee Schedules for welfare patients was presented in December to the Executive Committee, which instructed that the information be forwarded to all county medical societies.

* * *

THE FIRST MICHIGAN Cancer Conference, sponsored by the MSMS, the Michigan Department of Health, and the Michigan Division of the American Cancer Society was held in Lansing on October 11, 1949. The focus was on providing facilities throughout the state for the early detection of the disease.

The public relations program of the MSMS was presented as a case history study in the weekly Public Relations News. This top PR trade magazine devotes a portion of each issue to explaining and analyzing public relations activities selecting each week an outstanding example from a particular professional business field.

* * *

MICHIGAN AND its medical profession was signally honored in the selection of a Detroit physician to head the American Academy of General Practice for the ensuing year. E. C. Texter, M.D., became president in March.

The year 1949 marked the 100th birthday of the Wayne County Medical Society, and a ceremony was held in Detroit, April 26.

Attendance at the 1949 Annual Session of the MSMS in Grand Rapids, September 21-23, was 2,329.

The Michigan Health Council drafted plans for the reorganization of this body to include approximately 70 interested organizations. One of the

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The Author

WILLIAM J. STAPLETON, JR.
M.D.
MSMS Historian





E. F. SLADEK, M.D.
MSMS President 1948-49



W. E. BARSTOW, M.D.
MSMS President, 1949-50

first steps to be taken will be the hiring of a full-time executive secretary whose primary function will be to assist in the formation of community health councils.

And so ends another busy year for good medicine in Michigan.

—1950—

It always is almost impossible to single out any one event or action as most important of the year. Such a spotlight might be focused on a postgraduate medical seminar held in November in Detroit when color television was used for the first time at such a Michigan medical program. Under the auspices of the Wayne State University School of Medicine, a two-day program of medical and surgical procedures was telecast in color from Grace Hospital to the Masonic Temple.

In a new public relations venture, press conferences were held in the various councilor districts, with the first experimental meeting in Bay City.

* * *

A SCROLL COMMEMORATING the University of Michigan Medical School Centennial was presented to University officials in September during the MSMS Annual Session in Detroit.

As a means of offsetting a drop in the active membership due to hundreds of transfers in 1951 to military membership, the Executive Committee authorized an invitational membership drive by the MSMS and county medical societies and the reprinting of the leaflet "Benefits of Membership in Medical Societies."

The 1950 House of Delegates instructed that a special committee be set up to analyze the Basic Science Law, with the idea of amending it.

The Michigan Tumor Registry, sponsored by the Michigan Pathological Society and other organizations, officially opened on January 1, 1950, at the Detroit Cancer Center. The main objectives of the Registry was: (1) consultation service to pathologists, (2) educational, on a professional level for postgraduate study in pathology and on a lay level through statistical evaluation of the material as it applies to early diagnosis, as it applies to approved types of treatment, (3) clinical correlation to assist physicians to evaluate exact pertinent statistical data, (4) research to assist the Detroit Institute of Cancer Research in obtaining material on malignant diseases for study.

Michigan Industrial Health Day was something new on the medical postgraduate horizon. This continuation course in Industrial Medicine was held in Ann Arbor.

The Michigan Rapid Treatment Center at Ann Arbor was closed in June. This center was established six years ago for the rapid treatment of venereal diseases and has treated 13,000 cases.

* * *

THE GROWTH OF THE Michigan Health Council was reported with an expansion of the voting membership from 4 to 24 members, expansion of associate membership from 0 to 27 Community Health Councils and an increase in Michigan Rural Health Conference co-sponsors from 41-68 organizations in 1950. Among the members who joined the Michigan Health Council were the American Cancer Society-Michigan Division, W. K. Kellogg Foundation, Michigan Educational Association, Michigan Agricultural Conference, Michigan Farm Bureau, Michigan Foundation for Medical and Health Education, Inc., Michigan State Grange, Michigan Health Officers Association, Michigan Home Economics Association, Michigan Public Health Association, Michigan Rural Teachers Association, and the Michigan Tuberculosis Association.

A total of 3,044 were registered at the 85th Annual Session of the MSMS in Detroit, September 20-22, 1950.

* * *

AS THE YEARS go on it is interesting to note how the Michigan State Medical Society kept to the fore in giving to its members a well-rounded picture of the work done in the medical world. Not only does it tell the story, but it provides funds, gives Postgraduate Courses and in its two yearly meetings brings the membership up to date in medicine in all its branches.

Political Laryngitis

"So many professional people who are willing to work for the community chest or the heart fund refuse to participate in the political life of their community. They act as if politics will go away if they neglect it. But whether you like politics or not, you are in it."

—U. S. SENATOR HUGH SCOTT
Pennsylvania

Welcome, New Members!

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General

All M.D.'s Invited:

MAP Congress Set March 26-27

The 6th Annual Congress of the Professions, sponsored by the Michigan Association of the Professions, will be held in Grand Rapids, March 26-27, 1965. The Pantlind Hotel will be headquarters for the meeting.

Previous Congresses of the Professions have received national recognition for their excellence and preparations have gone forward to make this program of equal caliber to those of the past.

Program planners indicate that the Congress will consist of two sections: The first will be one in which the professions look at themselves; the second will have the professions looking at others with whom they have relations.

More news about the Congress will be forthcoming. Meanwhile, all officers and members of the Michigan State Medical Society are invited to attend and urged to set aside March 26-27 on their calendars.

Chairmen Appointed to Head Committees of The Council

The MSMS Council on October 28 approved the appointment by Chairman Harold H. Hiscock, M.D., of the following doctors to serve as chairmen of the Council Committees:

Advisory Committee to the Executive Director, Harold H. Hiscock, M.D., Flint; Education Liaison Committee, Don Marshall, M.D., Kalamazoo;

Liaison with State Board of Registration in Medicine, K. H. Johnson, M.D., Lansing; Liaison with Michigan State Pharmaceutical Association, R. V. Daugharty, M.D., Cadillac; Liaison with State Bar of Michigan, W. M. Le Fevre, M.D., Muskegon; Liaison with Michigan Crippled Children Commission, A. C. Standard, M.D., Saginaw; Liaison with Michigan Hospital Service, H. H. Hiscock, M.D., Flint;

Liaison with Residents and Interns, N. D. Henderson, M.D., East Lansing; Committee on Alcoholism and Drug Addiction, R. C. Bates, M.D., Lansing; Committee on Awards, W. A. Hyland, M.D., Grand Rapids;

Committee on Courses on Medical Economics and Ethics, C. Howard Ross, M.D., Ann Arbor; Committee on Disaster Medical Care, G. L. Otis, M.D., Jackson; Committee on Health Fair Arrangements, D. W. McLean, M.D., Detroit;

Committee on Hospital Relations, R. V. Taylor, M.D., Jackson; Committee on Medicine and Religion, R. L. Rapport, M.D., Flint; Committee on Nursing, R. J. Mason, M.D., Birmingham; Committee on Rehabilitation, S. D. Steiner, M.D., Detroit;

Committee on Beaumont Memorial, R. J. Mason, M.D., Birmingham; Committee on Retirement Plan, R. K. Whiteley, M.D., Detroit; Committee on Uniform Fee Schedule for Governmental Welfare Agencies, W. M. Le Fevre, M.D., Muskegon; Committee on Veterans Affairs, William Bromme, M.D., Detroit; Committee on Workmen's Compensation, William Jend, Jr., M.D., Detroit; Committee to Study Establishment of MSMS Service Corporation, O. B. McGillicuddy, M.D., Lansing; Committee on Relative Value Study, A. J. Neerken, M.D., Kalamazoo.

Several other appointments are expected at the December 16 meeting of The Council.

WASHINGTON, D. C. — President Johnson has appointed M. Finettte Marzolf, M.D., formerly of Lansing, to the U. S. Board of Veterans' Appeals. She left Lansing in 1962 to become a medical consultant to the VA in Washington.

Predict Johnson Administration in Big Medicare Push

By the American Medical Association

WASHINGTON — The Johnson Administration has placed so-called medicare at the top of its legislative program for 1965.

In a policy paper issued a few days before the national elections, President Johnson said:

"First we must provide adequate hospital and nursing home care for our senior citizens by a sound program financed through contributory social insurance. I pledge that the legislation to accomplish this will head my program next year."

Administration forces in Congress expressed confidence that most of Johnson's legislative program would be approved next year in light of the Democratic victory Nov. 3.

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What members will be appointed to fill committee and subcommittee vacancies and what voting patterns will evolve, will have to wait on organization of the 89th Congress.

The House Ways and Means: This Committee, which handles tax legislation (including medicare) lost Democrat Ross Bass (Tenn.) through his election to the Senate and Republicans Bruce Alger (Tex.), Victor A. Knox (Mich.), and Steven B. Derounian (N.Y.) through defeat.

DETROIT—"The most important part of assuring good health and old age is the orientation both physical and emotional in the pregeriatrics years and the adjustment to the devices needed for aid at the time when the need for becomes apparent."

So declared Manual Rodstein, M.D., New York, in a major address November 15 here at the convention of the National Society for Crippled Children and Adults.

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GRAND RAPIDS — Featured speaker at the annual banquet of the Michigan Association of School Boards on Nov. 5 at the Pantlind Hotel was Homer H. Stryker, M.D., Kalamazoo, who gave his light talk about problems in business.

Michigan Leaders Talk at Mental Health Congress

CHICAGO—Michigan played a prominent role here in the AMA Second National Congress on Mental Illness and Health, November 5-7. The entire MSMS Mental Health Committee attended, along with other Michigan physicians.

Program participants included Robert A. Kimmich, M.D., Director of the Michigan Department of Mental Health, who was co-chairman of a workshop on "Criteria and Priorities" for mobilizing community health services in major metropolitan areas. Benjamin Jeffries, M.D., MSMS committee chairman, was co-chairman of a workshop on the "Role of the Private Practitioner" and M. A. Riley, staff assistant to MSMS Mental Health Committee, was a resource person to advise on the roles of state and county medical societies.

The purposes of the Congress were clearly stated by the chairman, Dana Farnsworth, M.D., of Cambridge, Mass. He explained, "We know that mental illness poses the largest unmet health problem in America. We know that one way to resolve this problem is by means of comprehensive community mental health programs. Furthermore, we even have matching funds available from the government for the creation of community facilities.

"What we don't have is wide-scale interest by the communities in doing something about mental illness."

For this reason the efforts of the mental health congress, Dr. Farnsworth said, were directed toward getting the nation's physicians active in organizing community mental health services.

"There was a time," he added, "when psychiatry was one thing, physical medicine another. But this has changed. Today the general practitioner and the specialist as well, have a role in providing care for mental disease just as they do for organic disease. We feel they also have a role in activating community interest in the need for mental health services."

MSMS CENTENNIAL SYMBOL USED FIRST TIME—ON COVER

Preliminary plans are well underway for the observance of the Centennial of the Michigan State Medical Society.

The Centennial celebration will begin at the 1965 Annual Session in Detroit, September 19-24, and continue for 12 months.

The Centennial symbol—printed on the cover of this issue of Michigan Medicine—will be used throughout the year.

Many of the plans will be reviewed by The MSMS Council at its meeting in East Lansing on December 16.

Watch future issues of Michigan Medicine for information about the many exciting activities that are proposed!

News; And It's Brief

SAGINAW—More than 255,000 visitors to the 1964 Saginaw County Fair had an opportunity to see the award-winning exhibit sponsored by the Saginaw County Medical Society. Under the guidance of Thomas O. Lohr, M.D., the county medical society put together an exhibit which featured "Home Care" as its theme. With an AMA "Homemaker Services" display as its focal point, the exhibit was supplemented by smaller individual displays featuring the Visiting Nurses' Association and the American Heart Association. Materials distributed at the exhibit included pamphlets featuring cancer detection, heart disease and visiting nurses.

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CADILLAC—E. F. Sladek, M.D., of Traverse City, a past president of MSMS, spoke here over WWTV about "Home Care in Michigan" on the Michigan Health Council "Accent" program.

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JACKSON—The Detroit Branch of the American Urological Association met here Nov. 11 to hear a program that included an evening address by John L. Emmett, M.D., of the Mayo Clinic.

The next meeting will be January 13 at the Wayne County Medical Society in Detroit.

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ANN ARBOR—Arthur T. Hertig, M.D., Harvard Medical School, will present the ninth annual Carl V. Weller lecture to the Michigan Society of Pathologists, at 1:15 p.m., December 12, Rackham Building, Ann Arbor. Dr. Hertig will talk on "The Human Trophoblast: A Resume of Some Aspects of its Development and Pathology."

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EAST LANSING—Scientists were prodded here to develop a language that researchers and others in technical fields can understand. Air Force Col. James A. Fava of the Office of Aerospace Research in Washington issued the plea before the Society of Engineering Science, Inc.: "The problem is we don't understand the jargon, the dialect or the words of the other fields so you can't go to it to retrieve some scientific material," he claimed.

Colonel Fava, director of the office of scientific and technical information, said that often one scientific field may have worked out a problem without another area knowing about it because they cannot understand the technical mumbo-jumbo used.

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MT. CLEMENS—Several thousand dollars in surplus funds remaining from the Macomb County Oral Polio Vaccination Program are being given to the Macomb County Chapter of the National Foundation, the Macomb County Society for Crippled Children and the Chesterfield Tornado Disaster Fund.

Community Health Week Makes Impact

Many County Societies Hold Special Events

"As Governor, I call upon the citizens, health professions, civic organizations and public schools to join in its observance to demonstrate to the people of Michigan the many health services and facilities that enrich their lives and to encourage community planning to meet their health needs of the future."

That proclamation by Governor Romney set the stage for the observance of Community Health Week across the state. Newspaper clippings, county society bulletins, radio and television reports, and letters all indicate that the Michigan observance in October was "the greatest yet."

Typical of the comments is a letter from an AMA staff executive, who declared, "I have just seen examples of materials Michigan utilized in the Community Health Week effort. It was a spectacular job, beautifully organized. Undoubtedly, the campaign had great public impact."

In Michigan, the effort was jointly conducted by the Michigan State Medical Society, the Michigan Health Council and the Michigan Association of the Professions—with excellent support also from the Michigan State Pharmaceutical Association.

Following is only a brief review of some of the projects:

At Cadillac—William W. Moon, M.D., appeared with John A. Doherty, Health Council executive, and others in a special half-hour television program over WWTV.

At Detroit—J. L. Hudson provided a window display which pointed out that "Community Health Week protects the priceless assets of good health by using all available means to insure a sound, physical well being."

In Muskegon—An ambitious week-long observance saw local physicians as donors at the Red Cross Blood Center, holding open house at various medical facilities and conducting a career program at Mercy Hospital. *The Chronicle* carried daily articles, one declaring that the "Community Is Rich In Medical Skills."



The standup tower, in the lower left-hand corner of this J. L. Hudson window in downtown Detroit, was one of the promotional hits of the Michigan Community Health Week.

Across the State—MSMS members displayed an attractive red-white-blue tower poster in their reception rooms.

At Escanaba—The *Escanaba Daily Press* reported that a new "Health Resources Guide for Teachers" had been distributed by the Michigan Health Council there and throughout the state.

Vote Five Physicians To Board of Mental Health Society

Five doctors were elected to the board of directors of the Michigan Society for Mental Health at its annual membership meeting. Elected for the first time were Marjorie P. Meyer, M.D., and Francis P. Rhoades, M.D., both of Detroit; and re-elected were Peter A. Martin, M.D., and S. D. Steiner, M.D., both of Detroit, and Raymond W. Waggoner, M.D., Ann Arbor.

The Society adopted a resolution of appreciation to O. R. Yoder, M.D., retired superintendent of the State Hospital at Ypsilanti.

Robert A. Kimmich, M.D., Director of the Michigan Department of Mental Health, was one of the speakers.

MARQUETTE — The Newberry State Hospital has opened a field office at Marquette as the Michigan Department of Mental Health seeks to improve its services.

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SAGINAW—The Saginaw County Medical Society has designated Carl G. King as its new executive secretary. He has operated the Doctors Business Bureau since 1947 and has been business manager and publisher of the county society *Bulletin* since 1949.

In January Issue

In the January issue of MICHIGAN MEDICINE watch for an authoritative paper by John A. Cowan, M.D., Director, Michigan Department of Health, Division of Adult Health, on the venereal disease problem in Michigan, including the problems and present philosophy of venereal disease control in the state.

Drs. J. H. Webster and John Postle report a cervical cytology survey in Emmet and Charlevoix Counties, including background information regarding organizational structures and details in regard to classification and interpretation of Papanicolaou smear data.

Dr. Colin Campbell, of the University of Michigan, discusses the prevention of post-spinal headache in obstetrics. Other timely articles include notes on partial amputation of the penis without post-operative stricture, traumatic chylothorax, and an interesting case report on a functioning pheochromocytoma with neuro fibromatosis but without hypertension.

Leukemia Findings Rated Top Medical News of '64

By the American Medical Association

Medical scientists found some strong evidence for the viral theory of human leukemia in 1964, stirring hopes for early proof of a virus-leukemia relationship and providing some of the year's top medical news stories.

A review of medical headlines in 1964 shows that other virus hunters made news, too. Investigators of viral hepatitis, for example, were heartened by a report that human hepatitis virus had apparently induced disease in a laboratory animal. If the work is substantiated, a long-needed break in hepatitis vaccine research would seem to be near.

Still other medical news in 1964 was made by:

—the harsh judgments on cigaret smoking rendered by the Public Health Service Surgeon General's Advisory Committee on Smoking and Health.

—emergence of the optical maser, or laser, as a potentially powerful weapon against some types of cancer, and ultrasound as an important diagnostic tool.

—the American Medical Association and the Food and Drug Administration as they began to trade information on drugs and drug therapy in a new program of cooperation and computerization.

—encephalitis of epidemic proportions in Texas and New Jersey, with a scattering of cases in several other states.

In some sections of the United States the medical news of the year was an epidemic. Infectious encephalitis, a viral disease believed transmitted in many cases by the bites of mosquitoes, appeared in epidemic proportions in parts of Texas and to lesser extents in Kentucky, Illinois and Colorado.

Elect Four Physicians To U. S. Congress

WASHINGTON, D. C. — Four physicians were elected to Congress at the November election. Incumbents Durward G. Hall, M.D., (R-Mo.) and Thomas E. Morgan, M.D., (R-Pa.) were returned to the House and Ernest Gruening, M.D., (D-Alaska) was re-elected to the Senate.

One physician, Tim Carter (R-Ky.), was sent to Washington for his first term.

Doctor Morgan coincidently defeated another physician, Paul P. Riggle, M.D., in the race for the 26th Congressional District seat from Pennsylvania.

Elect Physician To State Board Of Education

Leon Fill, M.D., Huntington Woods, will take office January 1, as one of the members of the new State Board of Education, following his election November 3.

A democratic candidate for the Board, Doctor Fill was the only physician elected to a position in Michigan government. The new eight-member State Board was created in the 1962 Constitution and has been vested with "leadership and general supervision of all public education, including adult education and instructional programs in state institutions, except as to institutions of higher learning granting baccalaureate degrees." In a pre-election statement, Doctor Fill expressed the opinion "that this body must exercise utmost caution to guarantee cooperation with other constitutional bodies designed to deal with education."



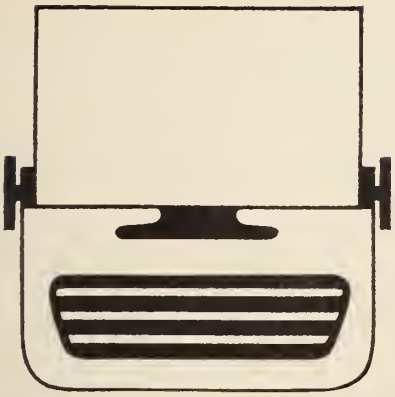
Doctor Fill received his B.S. degree at Wayne State University and his M.D. degree from Laval Medical School, Quebec.

Information Overload

The physician of today recognizes clearly his own personal responsibility for continuing self education. He meets this through postgraduate courses, local state and national meetings, conferences, and most commonly by way of journals. The physician, as much as any citizen, is brought to an immediate daily recognition of information overload with the arrival of each day's mail. In the mail, he receives a daily challenge to be critical in selecting his reading and thus guiding his own continuing education.

This challenge is accented by the Wall Street Journal which reports that enough technical papers are published in the world every day to fill seven sets of the twenty-four volume Encyclopedia Britannica. It is reported that there are 50,000 scientific journals being published; 60,000 scientific and technical books being printed yearly; 100,000 research papers, and 1,200,000 articles.

Information of this type gives pause to your editor who must strive at all times, therefore, to make the content of "Michigan Medicine" of sufficient interest, quality, and variety so that the members of our State Society can, in their critical judgment, place MICHIGAN MEDICINE among those self education devices that are utilized for information before the point of overload.



EDITORIAL VIEWS

Physician, Where Are You?

Medical manpower is always a topic of interest and it is generally accepted that there is a need for an increase in the output of physicians to meet the future needs of our nation. In addition, there are existing problems in the distribution of doctors in that some major communities have more physicians by far than other areas of the country. Greater productivity of the physician has clearly taken place in the United States where the number of physician visits has doubled in the past twenty-five years while the ratio of the doctors to the population has remained essentially stable.

It is interesting to note that this increased efficiency has not occurred in nations like England and the Scandinavian countries where no "economic bar" to the seeking out of medical service exists.

And yet, we are caught in a dilemma. On the one hand, the output of American medical schools has risen 117% in the last forty years while the population has increased 76%. On the other hand, the relative number of physicians in private practice has declined. In 1950, in the United States, there were 107 private practitioners per 100,000 members of the population. By 1955, this number had fallen to 102 and, by 1960, had fallen further to 98 and rested, by 1962, at 97 physicians per 100,000 members of the population.

Yet, at that same time, the total number of doctors of medicine increased from 232,000 in 1950 to 289,000 in 1962. Over that period of time, the ratio of physicians to the population remained relatively constant.

One seeks, then, to learn where the physicians have gone who are no longer in private practice. The largest area is that of training programs. A total of 21,400 physicians were in training programs in 1950 and an additional 10,000 were thus occupied by 1955, with the figure rising further to 38,517 in 1962. In the year 1950, 12,576 physicians worked for the Federal government in one capacity or another, including the military. Those employed by the government had risen in number to 14,212 by 1960 and to 18,551 by 1962. All other non-federal, non-private practice, non-training physicians totaled 16,800 in 1950, had increased to 25,197 by 1955, and to 29,686 by 1962. This last category includes physicians employed by pharmaceutical houses, non-federal governmental units, industrial physicians, insurance company physicians, and similar areas.

It would appear, then, that nearly 40,000 doctors of medicine are sequestered in training programs of one kind and another. In fairness, however, it should be recognized that these physicians in training do render a significant amount of patient service, even though they are not counted, nor should they be, in the private practice category.

It seems clear that we must seek even greater productivity of the physician and continued improvement in the use of medical facilities, resources, and personnel. We must look for more ambulatory instead of inpatient care, the continued development of home care programs similar to those now existing in nine Michigan counties, progressive hospital services, and an increase in production of manpower in all of the paramedical personnel areas. Many governmental agencies are involved in health care and in health care training today. In our free society, we must continue to look for private enterprise for leadership in all of these public functions.

Concern for "Crocks"

By John V. Fopeano, M.D.
Kalamazoo

The term "a crock" as applied to a fellow man is a cruel word and may have contributed much to dissatisfaction with medical care.

This informal diagnosis heard so often in the corridors of hospitals and coffee rooms may serve some useful purpose, but the gestures associated with its use make it a very damaging word—the pained facial expression of the speaker, the shrug of the shoulders, the significant sigh and other signs of irritation which close the door to further serious diagnostic efforts in the patient's behalf. This combination of word and gesture does violence to the professed interest of the doctor in the care of the sick and to the posture of the medical profession as the champion of suffering humanity.

The use of this term brands a patient in such a way that he is often deprived of the help which is available from persons with a different frame of reference.

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JUST WHAT IS a crock? The term "crock" as applied to a human being is defined as a "worn-out superannuated person" but as used around the hospital it seems to be applied to a complaining person of any age for whom the speaker feels little can be done, and with whom he doesn't feel comfortable. More often than not it refers to someone who is not well understood, for whom there is no empathy, vanishing interest and little sympathy. He is a person who is thought to be beyond the reach of medicine in its present state of knowledge and development.

There is a strong temptation to try to wish such a person out of mind. This is done in various ways. One of the most unsatisfactory techniques of wishing him away is to call him a neurotic or crock and thereby deny responsibility.

It is certainly true that there are persons for whom a certain individual doctor can do nothing. By reason of a different cultural background or limitations of training and experience, one doctor may be completely unable to understand, sympathize with or even tolerate a certain type of patient. If medicine is to remain a free profession such a doctor should not be compelled to treat such a patient.

FORTUNATELY, HOWEVER, that which is one man's poison may be another man's meat. A rag, a bone and a hank of hair may be someone's Lady Fair. If not, it is futile and dishonest to advocate programs that promise every man medical care and respect for his personal dignity.

One doctor's crock may be many things to some other doctor; an interesting example of pellagra, hypothyroidism, chronic nephritis or some inborn error of metabolism, or perhaps he is material for research on arthritis or arteriosclerosis or genetics, or a challenge to those who are concerned with rehabilitation. To those interested in the broader aspects of disease he may represent an inspiring symbol of courage in the face of overwhelming odds or teaching material illustrating the mental mechanisms used to achieve peace of mind in the face of a cruel world. To someone he may be a benevolent benefactor who deserves a lifetime of gratitude and solicitous concern; to another a symbol of family stature.

To those who are trying to understand the sociology of disease he may be a problem of special interest illustrating the effect of urbanization upon family relationships or the interaction of persons with various cultural backgrounds. To others, one doctor's crock may represent a client who is in the market for sanitarium care or a good nursing home, or a consumer of goods and services for which he is able to pay.

To the politician he is a potential voter who will help to provide support for or against certain legislation. To some others he is an economic problem requiring help from private charity or from the various agencies equipped to meet these needs, such as the Bureau of Social Aid and Welfare, Family Service Centers, Visiting Nurses, Meals-On-Wheels, Friendly Visitors, etc. To still another he may be an unhappy soul seeking his God and of great interest to ministers of the Good News.

The list could be extended but this is enough to make the point.

* * *

THERE IS REASON to believe that everyone is or can be a person of interest to someone somewhere. He might even be of interest to his present doctor if that doctor would not too quickly close his mind to that possibility and avoid that attitude which is betrayed by the use of the diagnosis "a crock."

MSMS President Appoints Committees for 1964-65

Oliver B. McGillicuddy, M.D., MSMS President, announces the appointment of the following members as chairmen of MSMS Committees for 1964-65:

Advisory Committee of Past Presidents, O. J. Johnson, M.D., Bay City; Advisory Committee to Michigan State Medical Assistants Society, G. E. Millard, M.D., Detroit; Advisory Committee to Woman's Auxiliary, Milton R. Weed, M.D., Grosse Pointe Park; Committee on Aging, A. Hazen Price, M.D., Detroit;

Annual Session Program Committee, H. A. Towsley, M.D., Chairman, Ann Arbor; Committee on Blood Banks, L. W. Walker, M.D., Lansing; Committee on Cancer Control, H. J. VandenBerg, Jr., M.D., Detroit; Committee on Cardiac Disease Control, S. E. Chapin, M.D., Dearborn; Committee on Child Welfare, W. Kaye Locklin, M.D., Kalamazoo; Committee on Diabetes, W. M. Le Fevre, M.D., Muskegon; Committee on Ethics, E. A. Osius, M.D., Chairman, Detroit; Committee on Highway Accident Prevention, J. R. Rodger, M.D., Bellaire;

Committee on Iodized Salt, B. E. Brush, M.D., Detroit; Committee on Legal Affairs, Otto K. Engelke, M.D., Ann Arbor; Committee on Maternal Health, W. W. Jack, M.D., Grand Rapids; Committee on Mediation, D. R. Boyd, M.D., Muskegon; Committee on Medical Socio-Economics, H. F. Falls, M.D., Ann Arbor; Committee on Medicine and Osteopathy, J. J. Coury, M.D., Port Huron;

Committee on Mental Health, Benjamin Jeffries, M.D., Detroit; Committee on Occupational Health, E. A. Irvin, M.D., Dearborn; Committee on Postgraduate Medical Education, H. A. Towsley, M.D., Ann Arbor; Committee on Professional Insurance Plans, Fredrick Weissman, M.D., Southfield; Committee on Public Health, O. D. Stryker, M.D., Mt. Clemens; Committee on Public Relations, R. W. Teed, M.D., Ann Arbor; Committee on Respiratory Diseases, R. A. Rasmussen, M.D., Grand Rapids;

Committee on Rural Medical Service, R. E. Rice, M.D., Greenville; Committee on Scientific Radio and Television, G. H. Lowrey, M.D.; Committee on Venereal Disease Control, R. L. Mainwaring, M.D., Dearborn.

MICHIGAN AUTHORS

R. J. Allen, M.D., and **J. L. Wilson, M.D.,** Ann Arbor, "Urinary Phenylpyruvic Acid in Phenylketonuria," The Journal of The American Medical Association, Vol. 188, No. 8, May 25, 1964.

Jack C. Westman, M.D., Ann Arbor, "Nursery School: Outpost of Preventive Psychiatry," The Archives of General Psychiatry, January, 1964, Vol. 10.



MSMS Concern for Aged Cited; New Booklet Offered

The Michigan State Medical Society is listed among "Statewide Organizations Interested in Older People" in the recent Michigan Commission on Aging publication, entitled "Services Available to Michigan's Senior Citizens."

The booklet also points out that MSMS and many of the others "have local advantages now available to Michigan's older people." The list of services includes health care, mental health help, housing, employment opportunities, adult education, and others.

A copy may be obtained from the Michigan Commission on Aging, 230 N. Grand, Lansing.

The 12-member Commission includes Albert E. Heustis, M.D., Lansing; Robert Kimmich, M.D., Lansing; Alexander H. Hirschfeld, M.D., Detroit, and Ruth E. Preston, M.D., Detroit.

MICHIGAN MEDICAL EVENTS

December 2—Annual Symposium on Trauma, Wayne County Medical Society, Detroit

December 3— American Academy of General Practice, Vascular Day, Bancroft Hotel, Saginaw

December 16-18—Michigan State Health Conference on Epidemiology, Jack Tar Hotel, Lansing

1965

February 22-26— Canadian-American Medical and Dental Ski Association, Boyne Highland, Harbor Beach

March 26-27—Congress of Michigan Association of the Professions, Pantlind Hotel, Grand Rapids

April 25—Michigan State Medical Assistants Society Seminar, April 25, Ann Arbor

FREDERICK AMASA COLLER, M.D.

Dr. Frederick A. Coller, one of the world's most distinguished surgeons and chairman-emeritus of The University of Michigan Medical School's Department of Surgery, died November 5 after a long illness at his Ann Arbor home. He was 77 years of age.

Once referred to as "a surgeon's surgeon," Doctor Coller was repeatedly honored, both in the United States and throughout the world, for his superlative professional skill.



One of these many honors came in February, 1963, when this Journal presented its "Master Surgery Member" and used on the cover of that issue a picture of Doctor Coller. An article in that issue, cited the impact of Doctor Coller's teaching throughout the world.

Another high tribute to Doctor Coller was the formation of the Frederick Coller Surgical Society. Brought into being out of admiration for their teacher, the society is composed of some 200 surgeons who took their training at his hand during his 27-year chairmanship at the University of Michigan. Almost exactly a month before Doctor Coller's death, the society held its 10th annual meeting in Ann Arbor and was addressed by the man it honors.

Born in Brookings, South Dakota, on October 2, 1887, Doctor Coller received his early education in public schools there. He earned a BS degree from South Dakota State College in 1906 and a master of science degree from the same institution in 1908. While in college, he captained the track and basketball teams and was president of the State Athletic Association.

Doctor Coller received the Doctor of Medicine degree (cum laude) from the Harvard Medical School in 1912, having been president of his class in 1909 and 1910, and a member of all the honorary societies.

He took his internship and residency training in surgery at Massachusetts General Hospital and, in 1915, served as resident surgeon with the First Harvard Unit to France during World War I. In October, 1922, he became a Fellow of the American College of Surgeons.

Doctor Coller joined the faculty of the U-M Medical School in 1920 as assistant professor of surgery, was named associate professor in 1923, professor of surgery in 1925 and chairman of the department in 1930, a position he held until his retirement in 1957.

He had been consultant-surgeon on the staff of the St. Joseph Mercy Hospital, Ann Arbor, from 1932 until the time of his death.

Doctor Coller was named a Fellow of the Royal College of Surgeons (Edinburgh) in 1954, the Royal College of Surgeons (England) in 1955, and an Honorary Fellow of the Royal College of University Surgeons of Denmark in 1963.

He received honorary degrees and awards from South Dakota State College, Hampden-Sydney College, Cleary College, Washington University, and an honorary doctor of laws degree from the University of Michigan in 1959.

He received a citation and gold medal from the Massachusetts General Hospital in 1961, the Faculty Award recognizing distinguished achievement from the U-M Development Council in 1957, and was elected to the Michigan Hall of Medical Fame in 1961.

Doctor Coller was president of the American College of Surgeons (1949-50) and had been a member of that organization's advisory council since 1951.

During World War II, Doctor Coller worked with the National Research Council and Office of Scientific Research on Committees on Surgery, Drugs and Medical Supplies, Infected Wounds and Burns. He served as a consultant to the Surgeon General's Office and was a member of several wartime committees of the American College of Surgeons, especially those working on problems of postwar medical education. He was also a member of the Advisory Board of Health Services of the American Red Cross.

Doctor Coller was a member of Alpha Omega Alpha, Phi Rho Sigma, Phi Kappa Phi, and Sigma Xi fraternities. During his career, he was the recipient of 16 lectureships.

Annals of Surgery, official publication of the American Surgical Association, the Southern Surgical Association, the Philadelphia Academy of Surgery, and the New York Surgical Society, published a 352-page Frederick A. Coller Commemorative issue in Doctor Coller's honor in 1961.

Doctor Coller is survived by his wife, Mrs. Jessie Coller; a daughter, Mrs. Jean Coller Allen of Midland, Texas; seven grandchildren; and two sisters, Miss Helen Coller and Mrs. Harry Innan, both of Laguna Beach, California. Another daughter, Carolyn Coller Ladd, preceded her father in death.

Funeral services were held in Ann Arbor. Memorial contributions may be made to the Frederick A. Coller Foundation at St. Joseph Mercy Hospital, Ann Arbor.



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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

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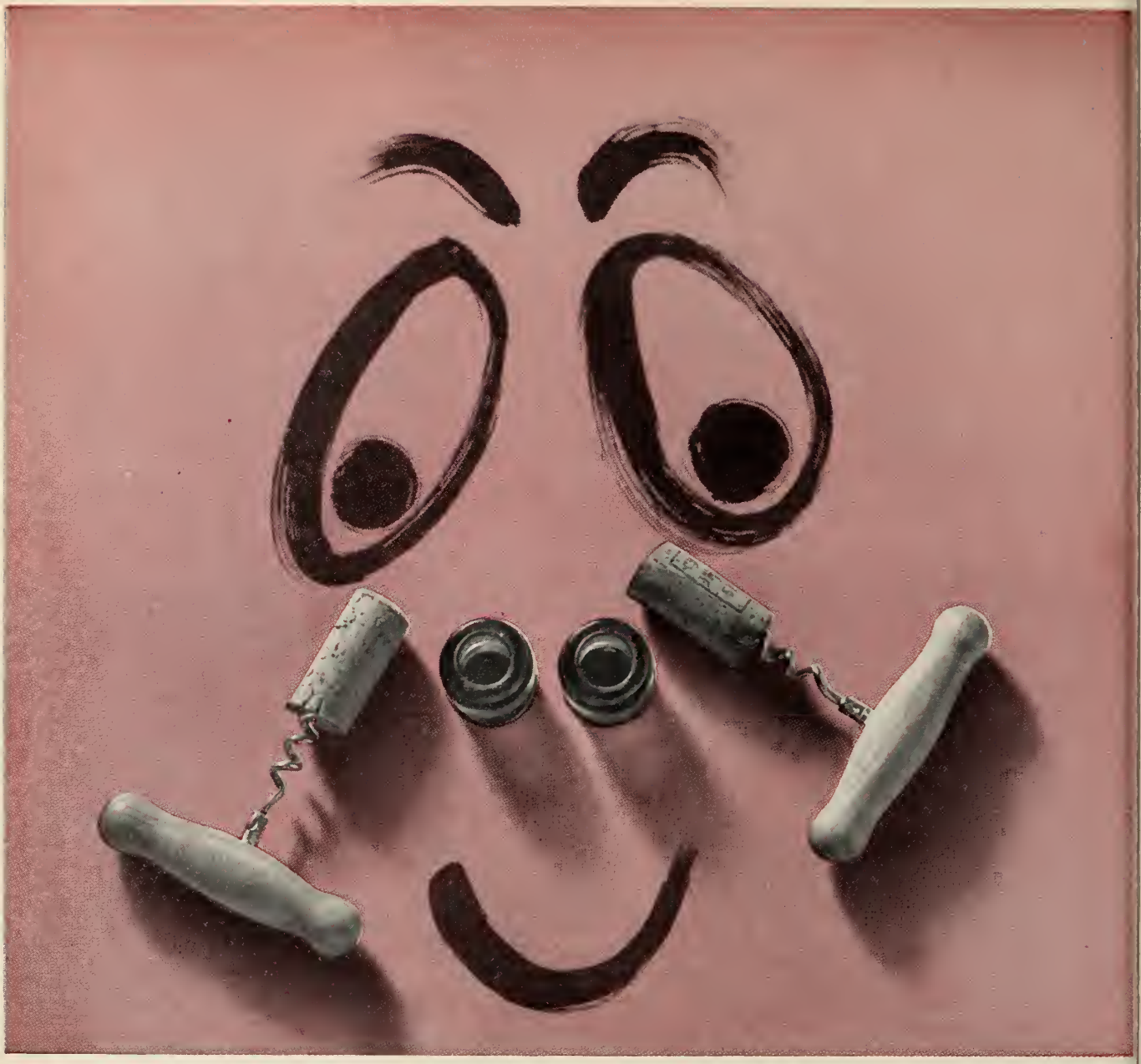
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Say you saw it in Michigan Medicine

LEGAL OPINIONS

Legality of Nonprofessional Persons Treating Occupational Injuries

By LESTER P. DODD
MSMS Legal Counsel

Dear Doctor:

I have your recent inquiry regarding the Legality of non-professional persons treating occupational injuries and other conditions in first-aid stations and clinics in Michigan.

Let me say at the outset that it would appear to be elementary that any treatment of occupational injuries or other physical conditions by non-professional persons which goes beyond the rendering of first aid is illegal.

The practice of medicine is defined in the Michigan Medical Practice Act (Section 14.539 M.S.A.) as "the actual diagnosing, curing or relieving in any degree, or professing or attempting to diagnose, treat, cure or relieve any human disease, ailment, defect, or complaint, whether of physical or mental origin, by attendance or by advice, or by prescribing or furnishing any drug, medicine, appliance, manipulation or method, or by any therapeutic agent whatsoever."

* * *

PRACTICING AS A registered nurse is defined in the Nursing Practice Act (Section 14.690 M.S.A.) as "performing any professional service requiring the application of principles of nursing based on biological, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of same, and execution of treatments and medications as prescribed by a licensed physician, ********."

The practice of licensed practical nursing is defined in the same statute as "the performance of such duties as are required in the physical care of a patient and in carrying out of medical orders as prescribed by a licensed physician, requiring an understanding of nursing but not requiring the professional service as defined above (with respect to R.N.'s) *******."

* * *

ALTHOUGH THE COURTS have never shown a disposition to construe these statutory provisions with such technical nicety as to discourage the maintenance or use of first-aid stations and facilities, I think it obvious that the latter can never legally be permitted to take the place, when possible to make it available, of adequate licensed medical and nursing care.

One of the key words in the definition of medical practice is "diagnosing" and it is in this area that I believe one of the principal dangers lies in leaving it to non-professional persons to determine what care or aid should be given. Obviously, also, the care that is prescribed to follow an accurate diagnosis requires professional competence even in the case of seemingly minor injuries and should not habitually or as a matter of common practice be left to non-professional persons.

In my opinion, therefore, any first-aid station or clinic which assumes, as a matter of common practice, to give complete care to injured persons at the hands of non-licensed persons is in violation of both the letter and spirit of the law. By complete care I mean follow-up care beyond elementary first aid or by failing to refer patients to a licensed practitioner when more than elementary first aid is indicated.

Specifically you have asked my opinion as to "the legal status" of nursing care in industrial first-aid stations and clinics with respect to (1) Registered Nurses (R.N.'s), (2) Practical Nurses, and, (3) graduate Red Cross First Aid personnel. Since discussion of any of these points must necessarily take into account the degree to which the services are performed under the supervision and direction of a licensed physician, I shall attempt to summarize each in relation to the degree to which such supervision and direction is furnished.

1. R.N.'s

Generally speaking, it must be kept in mind that even an R.N. may not legally diagnose or prescribe but must act always at the direction of a licensed physician. Under the direction of a licensed physician, an R.N. may, of course, do many things that are not permitted to be done by a practical nurse or a layman as, for example, giving injections, drawing blood or giving medications. She may not, however, do these things in the exercise of her own independent judgment. It would appear to follow, then, that

(a) If a doctor is actually present, a registered nurse may perform any commonly accepted nursing practice to the same extent that she would be

permitted to do in a hospital or in a doctor's office.

(b) If a doctor is in frequent attendance and actually sees and diagnoses the patient and leaves standing orders for continued nursing care, she could continue to carry out the doctor's orders even though he were not actually present.

(c) If, however, a doctor is only infrequently in attendance and leave only general "nursing orders" which do not relate to particular patients but amount to no more than general instructions under which the nurse is permitted to make her own diagnosis and exercise her own judgment, such practice would not, in my opinion, be legally acceptable.

The whole situation, it seems to me, boils down to a rather simple, basic consideration—is the patient diagnosed and treated under the direction of a physician or is he for practical purposes diagnosed and treated by a nurse. The former is acceptable. The latter is not acceptable.

2. PRACTICAL NURSES (L.P.N.'s)

Since an L.P.N. is far more restricted in what she can legally do than is an R.N., it follows, of course, that all of the restrictions which I have pointed out above as applying to R.N.'s must also apply to L.P.N.'s in addition to other restrictions which do not apply to R.N.'s. For example, L.P.N.'s may not legally give injections, draw blood or administer medications. Nor may an L.P.N. exercise the same degree of judgment in following out a physician's orders as might be permissible for an R.N.

3. FIRST-AID PERSONNEL (Red Cross trained)

Clearly, first-aid personnel may legally perform such services only as are recognized first-aid measures. They may not diagnose or prescribe or render follow-up care on their own responsibility. It is important to keep in mind that first-aid personnel, no matter how well trained, function for the purpose of rendering first aid and are not to be regarded as substitutes for physicians and nurses in the care and treatment of the sick or injured.

I am sure that no one wants to be super-technical about minor encroachments upon the practice of medicine or nursing in isolated instances. I feel, however, that if a first-aid station or clinic is set up and operated upon a basis which contemplates furnishing not merely first-aid but assumes to give follow-up care or complete care without such care being under the direction and responsible supervision of licensed physicians and nurses, such operation is not legally defensible and is dangerous not only to patients but to the doctors and nurses who associate themselves therewith.

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Officers of the Woman's Auxiliary to MSMS were installed at the annual Auxiliary convention in Detroit. They are, left to right, Mrs. Wm. G. Gamble, Jr., Bay City, Second Vice-President; Mrs. Henry Scovill, Ypsilanti, First Vice-President; Mrs. Rufus H. Reitzel, Mount Clemens, President-Elect; Mrs. Milton R. Weed, Detroit, President; Mrs. Robert J. Himmelberger, Lansing, Past President, who gives gavel to the new president.

Calhoun Medics, Pharmacists Meet

The Calhoun County Medical Society and the Calhoun County Pharmaceutical Association held a joint meeting in September at the Upjohn Company's Brookside Lodge near Augusta. The speaker was Norwood R. Newmann, professor of pharmacology at Ferris State College.



ANCILLARY SECTION

Flint Doctor to Head Radiology Board

Jackson E. Livesay, M.D., Flint, a former Speaker of the MSMS House of Delegates, will be installed in February as Chairman of the Board of Chancellors of the American College of Radiology. The installation will be at the annual College meeting.

Doctor Livesay, a past president of both the Detroit Roentgen Society and the Genesee County Medical Society, is a fellow and Chancellor of the College.

Internal Medicine Society Selects New Leaders

B. C. Payne, M.D., Ann Arbor, has been selected as President-Elect of the Michigan Society of Internal Medicine for 1965-66. Serving as the new President is Carl B. Beeman, M.D., Grand Rapids.

The Society also has renamed Richard C. Bates, M.D., Lansing, as Secretary-Treasurer, and elected the following as Trustees—Norman F. Bach, M.D., Owosso; Gordon W. Balyeat, M.D., Grand Rapids; Franklin W. Baske, M.D., Flint; John B. Bryan, M.D., Detroit; Hugh W. Henderson, M.D., Detroit; John G. Milliken, M.D., Traverse City; George W. Slagle, M.D., Battle Creek; Arthur W. Strom, M.D., Hillside; C. J. Tupper, M.D., Ann Arbor; Richard E. Wunsch, M.D., Traverse City; Clayton K. Stroup, M.D., Flint, immediate past-president, and Noyes L. Avery, Jr., Grand Rapids, as ex-officio member.

Grand Rapids Doctor to Lead General Practice Section

Fred C. Brace, M.D., Grand Rapids, will serve as chairman of the General Practice Section for 1965. He was chosen at the Section Meeting during the Annual Session.

Also named were Arthur Levant, M.D., Detroit, as Secretary. Douglas Haddock, M.D., Kalamazoo, was chosen as ex-officio delegate to the MSMS House of Delegates, and Lyle Korum, M.D., Detroit, as alternate.

Martin Schaeffer, M.D., Leads Detroit Psychoanalytic Society

Serving as President now of the Detroit Psychoanalytic Society and Institute is Martin Schaeffer, M.D.

Other leaders of the Society are Joseph Jacob, M.D., Vice-President; William Purves, M.D., Secretary; Paul Feldman, M.D., Treasurer; Morton Barnett, M.D., and Edward Fine, M.D., Representative Councilors, and Jean B. Rosenbaum, M.D., Program Chairman.

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Winthrop N. Davey, M.D. (left), of Ann Arbor, president-elect of the American Thoracic Society, and Gordon M. Meade, M.D., director, medical education, ATS, confer regarding programs to intensify control of tuberculosis at the recent annual meeting of the Michigan Tuberculosis and Respiratory Disease Association in Detroit.

P. T. Chapman, M.D., To Lead TB Society

Paul T. Chapman, M.D., TB controller for the City of Detroit, is the new President of the Michigan Tuberculosis and Respiratory Disease Association for a one-year term.

He succeeded Lloyd Humbarger, Battle Creek attorney, at the 57th annual meeting of MTRDA in Detroit, Oct. 22.

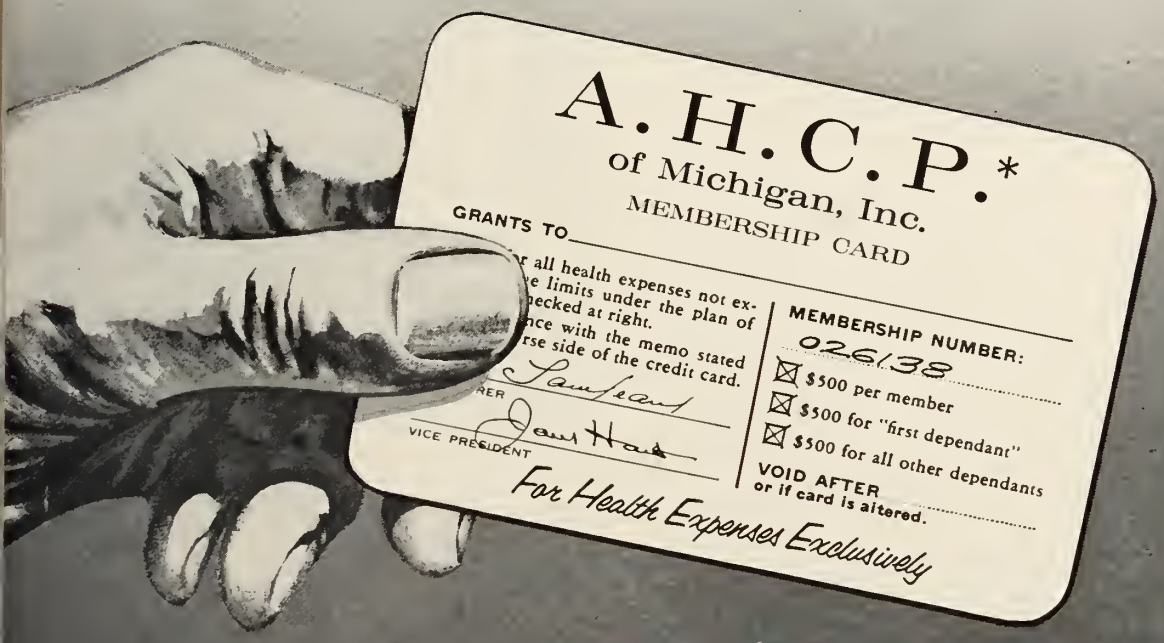
Arthur W. Strom, M.D., of Hillsdale, was elected second vice-president.

The board of trustees of MTRDA amended its by-laws to provide for the seating of three representatives to be designated by the Michigan Thoracic Society, thereby increasing its membership to 57. In state-wide membership balloting, three physicians were elected to serve three-year terms as MTRDA trustees-at-large. They are Ezra V. Bridge, M.D., Port Huron; Howard R. Eddy, M.D., Adrian, and Richard L. Jankoska, M.D., Bay City. Both Dr. Chapman and Winthrop N. Davey, M.D., of Ann Arbor, were re-elected by associations in their respective counties to serve as representative trustees on the MTRDA board.

Next Psychoanalytic Speaker

Natalie Shainess, M.D., New York City, will address the Detroit Psychoanalytic Society and Institute at 8 p.m., January 20, on the subject of "Female Sexuality," McGregor Memorial Building, Wayne State University.

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Say you saw it in Michigan Medicine

The Case . . . For Leadership

By Brooker L. Masters, M.D.*
11th District Councilor
Fremont

One of the pleasant surprises of my first year as Councilor has been the obvious awareness of the rank and file members of our society to the political and economic whirlwinds which are buffeting our profession.

The doctors I talk to are eager and even hungry for facts concerning the organization side of medicine. It seems to me that this is a switch—

It has long been a theory of mine, and of many others, that the average doctor, be he general practitioner or specialist, couldn't care less about what happened in Washington or Lansing. The body politic might just as well be left to a few die-hards who wanted to shoot their mouths off anyway. And because of this apathy, I thought, the general image that our formal organizations created was poor, and always defensive.

That theory may have been true, but perhaps it is no longer. Is not our present problem a dearth of vital and dynamic leadership?

* * *

"OPERATION COMMON MAN" which has been going on since the Industrial Revolution, or the Magna Carta if you insist, is one of the reasons why you and I have the opportunities we do today. It is a tremendous thing and morally right. But it is not without mixed blessings. The more society promotes the common denominator, the less it creates a climate conducive to strong leadership. Can society progress efficiently without a Washington, Disraeli, Lincoln, or a Churchill? This is an important question, I feel, and I would hope that some of you might pause for a few minutes to consider—

What odds there are against the development of truly great men today! The intense glare of public scrutiny in this mid-twentieth century would wither the most stout-hearted.

Where are the rewards?

Many times a leader steps forward only at the risk of personal sacrifice, be it his good name or even financial jeopardy. Certainly we have long made service and leadership a "poor pay" proposition. Only a few of the qualified make it through to success in face of this.

Now I feel this is wrong. We must be developing many minds capable of great leadership today. They need to be uncovered, nurtured, and supported. This is true in politics, foreign service, education, and in all facets of our society. Yes, and really so in medicine—(Haven't you wondered—and gazed in awe!—how Dr. Annis so quickly became the spokesman for the AMA? Isn't it only that even our august parent organization hungers for true dynamic leadership?)

* * *

WE HAVE MANY potential leaders in our midst I am sure. They will be stepping forward in the years to come, but they need support from all of us.

This applies to all levels. The chief of a section, chief of staff, delegate, president of a county or state society—all along the line—these should be the best men, not just one whose "turn" it is to serve. Then everyone should give him his best, not the cloak-room back-of-the-hand. He will make mistakes, for he is human. These should not be the cause for gossip or maligning, but for more help from the rank-and-file, especially if he is good enough to be elected in the first place. This kind of support will hatch leaders just as surely as water and fertilizer will produce a bumper corn crop!

Medicine has been the last to recognize its social position and obligations. We, therefore, need a big dose of the leadership hormone. Have you checked this titer in your county or state group lately?

*This article is reprinted by permission of the *Muskegon County Medical Society Bulletin.*

TV Cameras to Focus On Medicine, Religion

A television program, "Formula for the Whole Man" will be aired over WJIM-TV, Lansing, at 4:30 p.m. December 20, featuring the MSMS Committee on Medicine and Religion.

The pre-holiday time is ideal for this program and the Program Moderator Hugh W. Brenneman, MSMS Executive Director, will set the stage in his opening comments: "Physicians and clergymen are dedicated to the common task of healing bodies, minds and souls. The problems these men are concerned with are diverse and vital. They deal with life and death, adjustments to deformities and disabilities, suicide, terminal illness . . . even psychological disturbances."

The program will include Rev. Paul B. McCleave, Director of the AMA Department of Medicine and Religion; Richard L. Rapport, M.D., Flint, Chairman, MSMS Committee of Medicine and Religion; and W. Clarence Beets, M.D., Grand Rapids, a member of this new MSMS Committee.

The program is one of the weekly WJIM-TV public-service features presented by the Michigan Association of the Professions.



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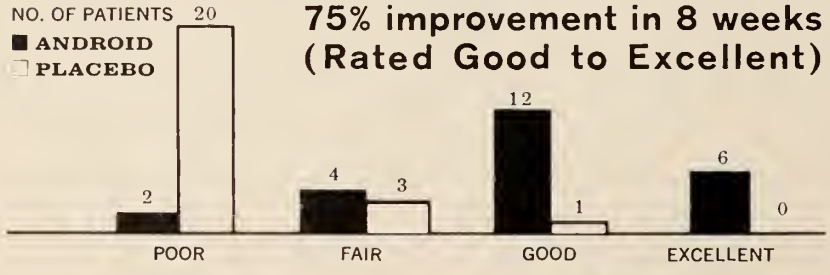
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* 1. *Treatment of Impotence with a Methyltestosterone-Thyroid Compound (Android)*, M. H. Dubin, *Western Medicine*, 5:67 Feb. 1964.
2. *Methyltestosterone-Thyroid in Treating Impotence*. A. S. Titeff, *General Practice*, Vol. 25, No. 2, February, 1962, pp. 6-8.
3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.
4. Brochure Discussing Thyroid-Androgen Interrelationship.



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Member, Illinois Senate

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"For my profit," he continued, "all I want is a note for thirty thousand dollars payable twenty years from now, and signed by your relatives and neighbors."

My first reaction was suspicious refusal. It seemed that he was making too much profit. There was too great a difference between five thousand dollars advanced now and thirty thousand dollars repaid in twenty years. But then the gnawing doubts began to assail me.

* * *

I WOULD NOT have to repay any of it. Perhaps my children and neighbors could easily afford the money when the debt came due. Perhaps none of them would be alive. Perhaps they will have moved away, and he cannot find them to serve the legal papers on them. Perhaps my grandchildren and neighbors can win the case in court twenty years from now. Perhaps there will be wild inflation then, and thirty thousand dollars will seem nothing. Perhaps this country will be conquered by another country, or become involved in a civil war, and the debts will all be voided.

If any of these things happen; if there is any kind of inflation, repudiation, or invasion, then I could beat the game and have a Cadillac for ten dollars.

And even if none of those things happen within the twenty years, my grandchildren and the neighbors' grandchildren can refinance the note and promise to pay sixty thousand dollars in twenty more years, and they can wait for the inflation, repudiation, or invasion.

* * *

THERE IS A GREAT TEMPTATION to gamble on the hope that Something Will Happen. Meanwhile, the Cadillac would be mine to enjoy. So I selected a white convertible, paid the ten dollars, and drove happily away.

But how did that huckster and I manage to get my relatives and friends to sign those notes? Easy! We cut them in on the same deal. And to salve their consciences, we put cars at the bottom of the list and offered them education, medical care, and similar goods and services that they desperately needed. We had no trouble at all in getting them to vote on the scheme and turn the whole thing over to our government officials to handle for us. After all, isn't that why we elect them?

So I am driving a white Cadillac. My elderly neighbors across the street are receiving their monthly checks from Washington. My neighbor's children next door are all in college at little cost to the parents. The other next-door-neighbor gets food coupons, plus a check from his government for not working.

And so on.

I expect that I will be dead before it is time to pay the piper. My grandchildren? Well, surely they will be at least as smart as I am. All they need do to beat the game in their time is to repudiate the debt, inflate the currency, or (if they are not too smart) refinance the national debt.

* * *

YOU KNOW, sometimes I suspect that something is wrong with this whole scheme of more benefits from Washington at no cost except an increase in the national promise to pay in the distant future. But I don't seem to be able to explain it—even to myself; after all, I *am* driving that white convertible.

*The Honorable Robert Coulson is a former Mayor of Waukegan, Illinois, now a member of the Illinois State Senate, a lawyer and banker and occasional contributor to magazines. The article is reprinted with permission of *The Freeman*.



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IN MEMORIAM

ROBERT S. BALLMER, M.D.

Robert S. Ballmer, M.D., 59, a former delegate to the MSMS House of Delegates, died November 8, 1964, in Midland.

A 1934 graduate of the University of Michigan School of Medicine, he interned at the University Hospital. Following his internship, he became resident in internal medicine and later an instructor in internal medicine at the University Hospital. In 1938 he entered private practice in internal medicine in Midland.

From 1948 to 1964 Doctor Ballmer was chief of medicine at Midland Hospital and served as chairman of the executive committee. He was also on the consulting staff of Saginaw General Hospital.

Doctor Ballmer was a Diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians and the American College of Allergists. His memberships included the American Academy of Allergy and the American and Michigan Heart Associations.

DONALD H. DUFFIE, M.D.

Donald Hastings Duffie, M.D., 84, retired Antrim County physician, died September 7, 1964, at the home of his son in Madison, Wisconsin.

A 1920 graduate of George Washington University Medical School, Doctor Duffie began practice at Central Lake in 1922. He continued his medical practice there until his retirement last year because of failing health.

Doctor Duffie was a Life Member of the Michigan State Medical Society.

LUCIUS A. FARNHAM, M.D.

Lucius A. Farnham, M.D., 87, Pontiac physician and surgeon for more than 50 years, died September 9, 1964.

Doctor Farnham graduated from the University of Michigan Medical School in 1905. He practiced in Trimountain, Michigan, for six years before beginning practice in Pontiac in 1911.

Doctor Farnham was mayor of the city of Pontiac in 1930, after serving as city commissioner for six years previously. He was on the staffs of Pontiac General and St. Joseph Mercy Hospitals.

Doctor Farnham was a Life member of the American College of Surgeons, a Fellow of the Academy of International Medicine and a Life Member of the Michigan State Medical Society.

JACOB D. MULDER, M.D.

Jacob D. Mulder, M.D., 79, Grand Rapids, retired superintendent of Pine Crest Christian Hospital, died October 14, 1964, of injuries suffered in an automobile accident.

Doctor Mulder obtained his medical degree from Rush Medical College, Chicago, in 1916, and spent six years as a missionary doctor among the Navajo Indians in New Mexico before beginning as superintendent of Pine Rest Hospital in 1922. He served as the Hospital's superintendent and medical director until his retirement in 1956, when he became a consulting psychiatrist to the Hospital.

Doctor Mulder was a Life Member of the Michigan State Medical Society.

MARCUS B. TIDEY, M.D.

Marcus B. Tidey, M.D., 67, former chief of surgery at Butterworth Hospital, Grand Rapids, died October 27, 1964, at Rockford.

Born in Newark, New Jersey, Doctor Tidey graduated from the University of Michigan School of Medicine and began practice as a surgeon in Grand Rapids in 1929. In 1956, Dr. Tidey moved to Rockford where he went into semi-retirement, resuming practice in 1960 until 1963.

Doctor Tidey was a member of the American College of Surgeons, Phi Chi medical fraternity and an Associate Member of the Michigan State Medical Society.

FRANK P. WALSH, M.D.

Frank P. Walsh, M.D., 52, Detroit orthopedic surgeon, died August 29, 1964.

Doctor Walsh was graduated from Northwestern University in 1939 and interned at Harper Hospital. He undertook postgraduate training at the University of Chicago Clinic's Home for Destitute and Crippled Children. His hospital affiliations included Harper, Woman's and Children's and St. John of Detroit.

He was a Diplomate of the American Board of Orthopaedic Surgery and a member of the American Academy of Orthopaedic Surgery, Clinical Orthopaedic Society, Detroit Academy of Surgery, American Rheumatism Association, Detroit Academy of Orthopaedic Surgery, and was a Civilian Consultant to the Surgeon General, United States Army.

Doctor Walsh was a former Associate Editor of the *Detroit Medical News* and a member of the Downtown Detroit Rotary Club.

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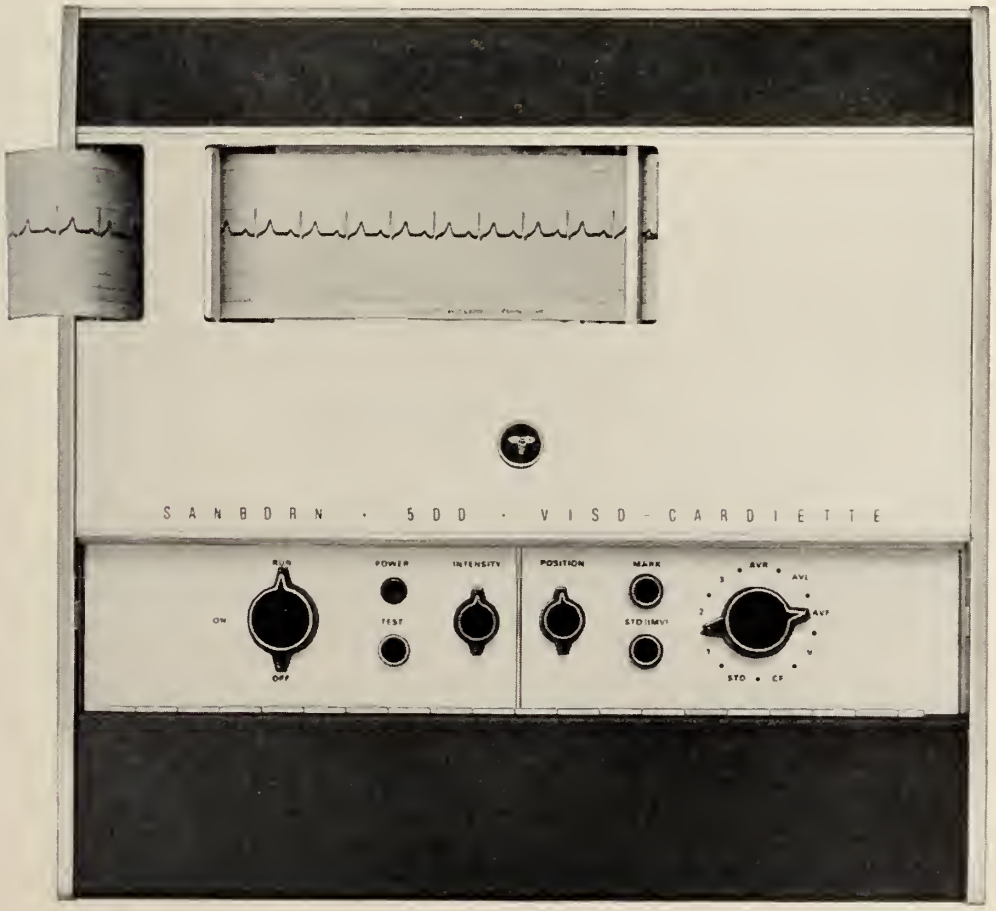


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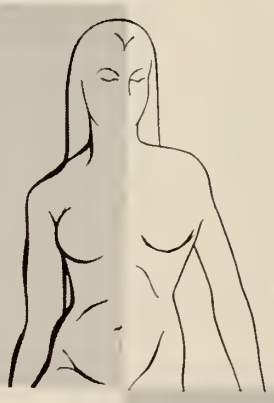
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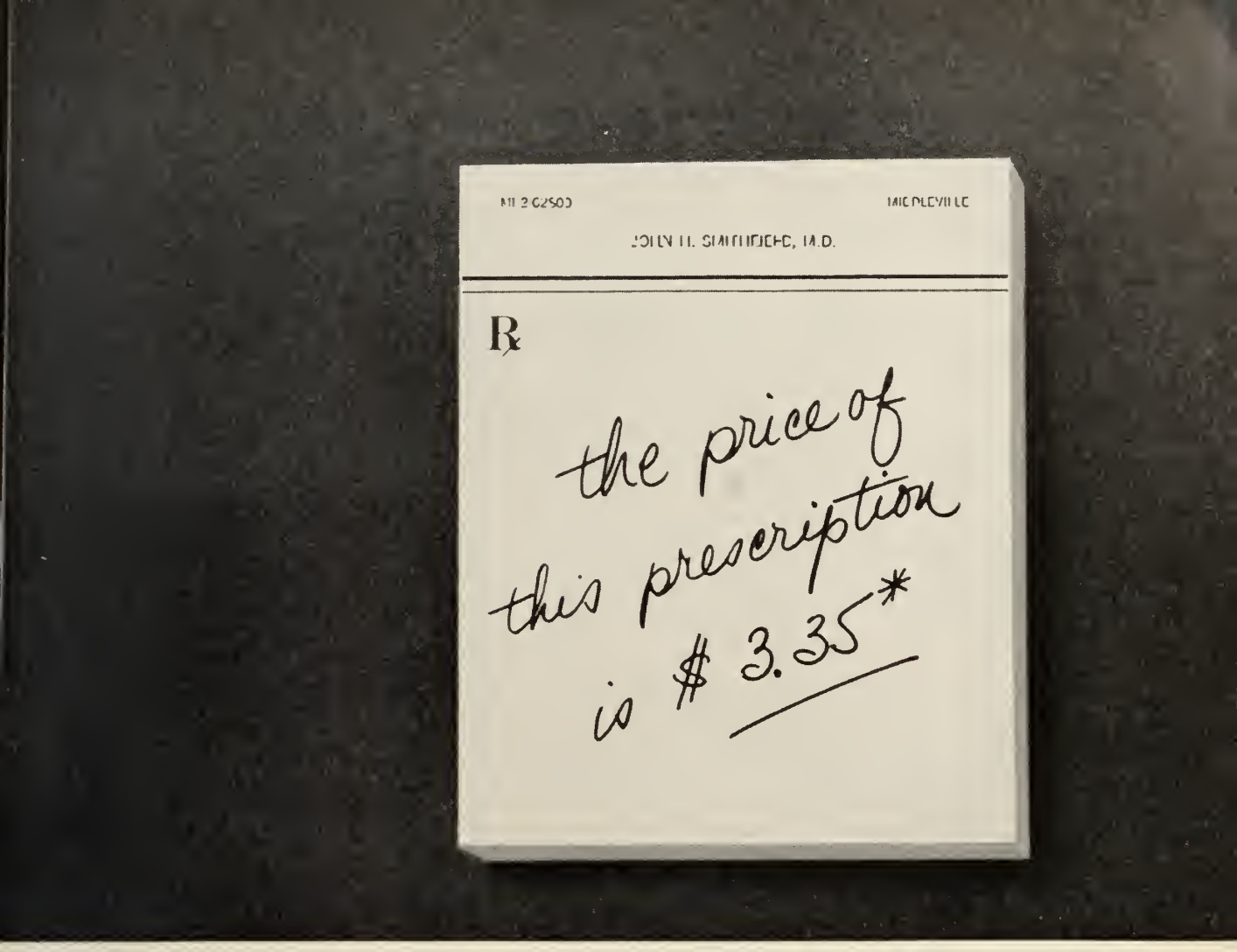
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W. A. Hyland, M.D., *Chairman*, Grand Rapids	1965
O. J. Johnson, M.D., Bay City	1965
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E. E. Martmer, M.D., Grosse Pte	1964
R. E. Rice, M.D., Greenville	1964
A. Hazen Price, M.D., Detroit	1964
Sidney Adler, M.D., Detroit	1965
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DIGEST OF PROCEEDINGS OF 1964 HOUSE OF DELEGATES



MICHIGAN STATE MEDICAL SOCIETY
99th ANNUAL SESSION, SEPTEMBER 20-22, 1964
DETROIT, MICHIGAN

This number is composed of two sections, of which this is Section 2

Michigan State Medical Society
Ninety-Ninth Annual Session
September 20-22, 1964

DIGEST OF PROCEEDINGS

1964 Digest Simplified for Quicker Reference

For convenient use of the *Digest of Proceedings,* the following procedure has been used:

Each report or resolution is followed immediately by the action of the reference committee on that report or resolution and then the House action on the report of the reference committee.

1964 House of Delegates Proceedings
Ninety-Ninth Annual Session
Michigan State Medical Society

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Michigan State Medical Society

Ninety-Ninth Annual Session

September 20-22, 1964

CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The annual meeting of the House of Delegates of the Michigan State Medical Society, held at the Sheraton-Cadillac Hotel, Detroit, convened at 8:10 p.m., September 20, 1964, J. J. Lightbody, M.D., Speaker of the House, and L. F. Hayes, M.D., Vice Speaker of the House, presiding.

2. Report of Credentials Committee

Chairman R. E. Rice, M.D. reported: "Mr. Speaker, there are 135 delegates seated, not more than 50 per cent from any one county."

3. Invocation

The Speaker called upon R. R. Cooper, M.D., to give the invocation.

4. Address of Milford O. Rouse M.D., Speaker, House of Delegates, American Medical Association

(Dr. Rouse was introduced by William A. Hyland, M.D. Following are extracts from his address).

It is really a personal pleasure to be in Michigan, where so many excellent accomplishments in the fields of health care and medical organization have been achieved.

Helping the American Medical Association in carrying out its many activities, I have counted a total of forty-five Michigan men—including your fourteen delegates and alternates in the AMA House of Delegates, and thirty-one others who are members of commissions, councils and committees, officers of scientific sections, and members of editorial boards for AMA specialty journals.

However, there is always a place for more, and I should like to suggest that you let the AMA officers and Trustees know about any and all Michigan physicians with the ability and desire to serve medicine on the national level.

For example, we could use more men like Dr. William A. Hyland, Chairman of the AMA Council on Constitution and Bylaws and of the Committee on Communications; Dr. George W. Slagle, member of the Council on Medical Service, and Dr. Frederick C. Swartz, who has been quite busy as Chairman of the AMA Committee on Aging.

During the recent past, I can recall the outstanding work and service of such men as Dr. Jack DeTar and Dr. Robert Novy.

These are but a few examples, past and present, and many more names could and should be mentioned if one were to attempt a complete list of Michigan's contributions.

Involvement on the national level by members of state and local societies is vital if we are to keep open the lines of communication without which we cannot function properly.

A three-point communications program designed to improve the public relations position of the medical profession was endorsed by the AMA House of Delegates. This program, contained in the final report of the AMA Committee on Communications, recommends:

1. That county and state medical societies redouble their communications efforts and that expressions of support be issued whenever and wherever unjust attacks are made on the AMA.
2. That physicians and staffs of state and county medical societies become acquainted with members of the communications media in their areas, and provide them with factual information concerning the medical profession. Further, that they call to the attention of editors and station managers any misstatements of fact concerning the AMA or its activities; and if correct facts are not available locally, that the medical society contact the AMA for the information needed.
3. That the AMA make "every effort" to inform state societies of news releases or testimony before Congress as soon as possible, and that spokesmen for constituent societies refrain from commenting on statements and policies until they are aware of their contents.

In conjunction with this recommendation, the House asked the Board of Trustees to investigate the feasibility of establishing a wire communications system between AMA headquarters in Chicago and offices of state medical associations. This proposal is now under active study.

A five-point program for the future development of American Medical Association activities—including a stepped-up program of continuing education and an increase in dues—was suggested to the AMA House of Delegates by Edward R. Annis, M.D., outgoing President.

In his report to the House, Dr. Annis said his visits to various state and county societies during the past year had impressed him with the need for improved communications both among physicians throughout the country and between the medical profession and the public.

To meet this need, he suggested:

A comprehensive program of postgraduate education for the practicing physician "so that we can better educate ourselves." Noting the rapid advancements now being made in medicine, he said, "We need more programs whereby this information can be made available to physicians at home." He suggested that the AMA look into the possibility of closed-circuit television as one medium by which such information might be transmitted.

Dr. Annis also observed that of the nation's 1,929 county medical societies, only 220 have paid executive staff members. He suggested that the AMA develop training programs for staff members of its constituent organizations, and develop the capacity for aiding small medical societies which have no staff or only part-time staff assistance.

He recommended an expanded program of health education aimed at all levels of the American public. This would

include, with the cooperation of state and county groups, such things as radio and television shows, health fairs, a health education forum, and increased activities by speakers bureaus.

It would possibly require establishment of a teletype or similar circuit linking AMA headquarters in Chicago with the headquarters of state and major county medical societies.

To finance the above programs, he suggested a series of dues increases, which ultimately might raise the AMA dues for the member physician from their present yearly level of $45 to about $100 a year.

Later in the meeting, a reference committee report proposing a dues increase on the national level was referred by the House to the Board of Trustees for study and a report at the 1964 Clinical Convention.

Dr. Annis placed much emphasis on activities conducted at the county level, and praised the work done by the 1,700 county societies without paid executives which "rely on busy doctors to take time from their prime purpose . . . to carry out programs suggested by their state and national organizations."

Many spokesmen—both in and out of medicine—have expressed intense concern over the rising tide of specialization in the United States during recent years. He said that while specialization has brought many valuable and diverse scientific achievements, it also carries with it risks, splintering effects, and the seeds for generating friction within the medical profession.

If we work together, if we open more paths of communication and cooperation between our various societies and between us and the people of this nation, then we can bring into being the goal sought by every physician who would follow our Oath.

Thank you very much.

5. Speaker's Remarks—J. J. Lightbody, M.D.

The introduction of resolutions will begin tonight as the last order of business. You will remember that at previous sessions resolutions could not be introduced until the Monday morning meeting.

As far as the resolutions themselves are concerned: When resolutions are called for tonight and at subsequent meetings, they will be presented in numerical order. The delegate who is to present a resolution will have the choice of reading the resolution by title only, or reading the Resolved portion of the resolution.

Each year there has been an increased number of resolutions, and each year we have tried to stimulate the interest of individual delegates and county medical societies in submitting their resolutions as early as possible so that they may be available to the delegates at the time of the mailing of the Handbook.

To further bring this point to the attention of the House of Delegates, I suggest that Chapter IX, Section 13 of the Bylaws be amended so as to include a deadline date for the submission of resolutions, and that resolutions submitted after that date could be admitted only after a two-thirds affirmative vote of the House. This cut-off date should be at least three weeks before the opening meeting of the House. A similar plan is in operation at the American Medical Association House of Delegates and has worked very satisfactorily.

During the past year between sessions of the House there have been seven House committees appointed and functioning. They have reports ready for the House. These committees are as follows:

1. Committee on Certificates of Commendation.
2. Committee on Constitution and Bylaws.
3. Committee on Emergency Care in Hospitals.
4. Committee to Study the Procedure of the House of Delegates.
5. Committee to Study Relationship Between M.D.s and Osteopaths.
6. Centennial Advisory Committee.
7. Committee to Study Section Representation in the House of Delegates.

The Committee on Certificates of Commendation will present its report tonight so that recipients of this award may be notified in time to be present at a subsequent meeting of the House.

The House of Delegates Committee to Study the Relationship Between Doctors of Medicine and Doctors of Osteopathy was combined with a similar committee of The Council, and this combined Committee report is being made available to the House and referred to the proper Reference Committee.

The ad hoc Committee to Study Procedures of the House of Delegates has made some excellent suggestions concerning the functions of the House in relationship to the format and agenda. A number of these recommendations are incorporated in this year's program.

All seven committee reports have been referred to reference committees.

To further inform the delegates concerning the implementation of last year's resolutions and other actions of the House, you will find in your Handbook a general summary of the business of the 1963 House of Delegates. This will give you considerable information as to what has transpired during the past twelve months.

As in previous years, the deans of our two medical schools have been invited to our meetings—Dean Hubbard, of the University of Michigan, and Dean Gardner, of Wayne State University. This year, for the first time, we have extended a formal invitation to Andrew Hunt, Jr., M.D., who is the new Dean of the two-year pre-clinical College of Human Medicine at Michigan State University.

We have also extended invitations to two senior and two junior medical students from each of our State medical schools, and also to two representatives of the Student American Medical Association.

Other distinguished guests who are present are: Mrs. R. J. Himmelberger, President of the Women's Auxiliary of the Michigan State Medical Society, and Mrs. Dorothy Brandis, President of the Michigan State Medical Assistants Society, who will present their greetings to the House at tomorrow morning's session.

At this time I am going to ask Dr. Rom, delegate from Wayne, to introduce the students from Wayne State University, and Dr. Towsley, of Washtenaw, to introduce the students from the University of Michigan.

In behalf of the House of Delegates, I want to welcome you young men of medicine to our meetings. You are invited to attend any of our reference committee sessions and any sessions of the House of Delegates.

This year, the installation of the new President will take place on Thursday evening, replacing the previous custom of having the ceremony in the House of Delegates on Tuesday evening. This change has been recommended particularly by the Committee of Past Presidents, who felt that a somewhat more elaborate and formal induction ceremony was indicated. This change, however, will leave us with two Presidents-elect for a period of two days, as the new President-elect will have been elected on Tuesday evening by the House of Delegates and the incoming President will not be inducted until Thursday.

In conclusion, your Speaker and Vice Speaker will do everything possible to make your attendance at this session an enjoyable experience, but at the same time appreciating the seriousness of our work and the necessity for orderly parliamentary procedures.

(The following report of the Speaker was presented to the Delegates in printed form.)

This is a brief review of the implementation of resolutions from the 1963 House of Delegates.

Resolution 1 requested component societies to make available sources of instruction in external cardiac massage to eligible persons in their areas.

This resolution was transmitted to component society secretaries and executive secretaries and subsequently component societies were requested for information regarding their implementation of the resolution. (See Annual Report of Committee on Cardiac Disease Control.)

Substitute resolution for Resolutions 2, 35, 41, 57 and 58 directed the establishment of a Liaison Committee with the Michigan Crippled Children Commission, recommended using services of hospital credentials committees in determining qualifications for elective surgery done under the

afflicted children's program, urged the MCCC to continue its efforts to revise and update its fee schedule and to take steps to simplify its billing procedure.

The Council appointed a Liaison Committee which, at its meeting with MCCC representatives, urged the steps indicated above. (See Annual Report of Liaison Committee with Michigan Crippled Children Commission.)

With the help of the MCCC, the MSMS Research Director and legislative staff, a new fee schedule was adopted by MCCC and approved by the Legislature, at 75% of the fees set forth in the MSMS Uniform Fee Schedule for Governmental Welfare Agencies.

The Commission reported to The Council of MSMS in July that the regulations requiring consultation for elective surgery had been removed from its procedures.

Resolution 3 recommended Council study of legislation to form a State Medical Disciplinary Board. The Council referred this matter to the Legal Affairs Committee. A Legal Opinion was rendered that such a Board is not possible under present Michigan law and the matter was referred to the Liaison Committee with the State Board of Registration in Medicine. The Legislature appropriated additional funds for the State Board of Registration to improve investigative functions of the Board.

The creation of a disciplinary board, under the terms of the resolution, is not possible under the Michigan Constitution. (See Annual Report of Liaison Committee with State Board of Registration in Medicine.)

The Council at its July meeting directed the Liaison Committee with the Board of Registration to further explore this subject.

Resolution 4 recommended changing the name of the Section on Nervous and Mental Diseases to "Section on Psychiatry and Neurology." This resolution was referred for study to an ad hoc committee of the House charged with studying the entire section structure. The committee in its report to the House of Delegates recommends approval of this change.

Resolution 5 instructed AMA Delegates to introduce and support a resolution favoring compulsory social security for physicians. Such a resolution was introduced by Michigan Delegates at the 1963 Interim Session of the AMA House of Delegates at Portland, Oregon. It was not adopted by the AMA House of Delegates.

A similar resolution was introduced at the 1964 Annual Session of the AMA House of Delegates and was supported by the Michigan Delegation. Shortly thereafter, a bill was reported out of the Ways and Means Committee of the U. S. House of Representatives, which provides for compulsory inclusion of physicians under Social Security. This provision was deleted by the Senate Finance Committee.

Resolutions 6 and 64 reaffirmed MSMS endorsement of a single medical practice act. The House referred these two resolutions for study to the Legal Affairs Committee. As a first step in this direction, the Legal Affairs Committee directed an attempt to repeal the Basic Science Act. A bill to repeal this Act failed of passage in the 1964 Legislature. A single medical practice act is not possible under the present Michigan Constitution.

Resolution 7 advised Michigan Delegates to the AMA to introduce and support a resolution recommending approval of the principle of a tax credit and/or partial government subsidy of prepaid health insurance for the needy. Such a resolution was introduced at the 1963 Interim Session of the AMA House of Delegates at Portland, Oregon. It was not adopted by the AMA House of Delegates.

Resolution 8, regarding the ethical relationship of doctors of medicine and doctors of osteopathy in Michigan, was referred to the Committee on Medicine and Osteopathy. Resolution 42 on this same subject was disapproved by the 1963 House since its intent was contained in Resolution 8.

Resolution 9 recommended that doctors of osteopathy be represented on the Michigan Medical Service Board of Directors. No action was taken on this resolution by the House since the matter was before the corporate body of Michigan Medical Service.

Resolution 10 directed that special assessments of MSMS membership be listed on dues statements as such and not included as dues. The MSMS Membership Director has been requested to apply this policy when such assessments are authorized in future.

Resolution 11 recommended that component societies establish mental health committees to work with local mental health boards in developing local mental health programs. By means of the County Societies Letter, component societies were urged to establish community mental health study committees.

Substitute Resolution for Resolutions 12, 19, 20, 21, 22, 23, 32, 33, 45, 47, 55, 60, 61, 67, 69, and 70 directed that the Relative Value Scale be not implemented but be studied further by the Relative Value Study Committee, and that any revised scale be submitted to MMS for monetary interpretation only, without implementation, and returned to the House of Delegates at a special or the next regular meeting. This entire matter is still being studied by the Relative Value Study Committee. (See Annual Report of Committee.)

Resolutions 13, 14, 15, 16, and 18, dealing with MSMS recommendations on reorganization of state government, were referred to the Legal Affairs Committee by The Council. The Committee transmitted the policies expressed in the resolution to the appropriate executive and legislative authorities and made known to the Governor the MSMS policy position. Follow-through is still in process since the reorganization of state government will continue through 1964.

Resolution 17 on this same subject was disapproved by the House.

Resolution 24 urged legislation to permit health insurance pooling plans in Michigan. The 1964 Legislature enacted enabling legislation for such pooling plans.

Resolution 25 authorized presentation of a plaque by the House of Delegates to retiring Executive Director Wm. J. Burns in recognition of his long service to MSMS. This plaque was presented to Mr. Burns during the 1963 Session of the House.

Resolution 26 called for MSMS support of a compulsory motor vehicle inspection law. MSMS supported such a bill in the 1964 Legislature, but the bill died in committee.

Substitute Resolution 28 directed that 75-80% of the Public Health and Legal Affairs Committees membership be composed of physicians in private practice. This policy was followed in 1963-1964 committee appointments and has been noted for future committee appointments.

Resolution 30 directed that certain questions regarding Michigan Medical Service future operation be referred to component societies for their consideration, discussion and crystallization of membership opinion. Such a questionnaire was sent to component society secretaries and a report of the replies has been supplied to the appropriate reference committee of the 1964 House of Delegates as background information.

Resolution 31, urging MSMS support of a third medical school at Michigan State University by the expansion of the present two-year program, was referred to The Council for study. The Council referred this question to the County Societies Committee which is continuing its study and review of developments at MSU in the light of this resolution.

Resolution 34 strongly urged that non-emergency medical care in hospitals be not a contract benefit of Michigan Hospital Service. This resolution was referred by the House to the Standing Committee on Emergency Care in Hospitals. (See Annual Report of Committee.)

Resolution 36 directed MSMS to give full support to the observance of Community Health Week. The AMA Com-

munity Health Week kit, supplemented by additional material from MSMS and Michigan Health Council, was distributed to all component societies. Several television appearances were made, as well as many appearances of doctors at service clubs, and radio spots by MSMS President Johnson, were furnished all radio stations in Michigan. AMA advised that the Michigan observance of Community Health Week was one of the best in the country.

Resolution 37 directed that the House of Delegates consider presentation of a tangible token of appreciation to retiring Executive Director Wm. J. Burns. At the 1963 State Society Dinner Dance in Grand Rapids, a suitable presentation was made to Mr. Burns.

Resolutions 38 and 39 were disapproved by the House.

Resolution 40 reiterated MSMS policy of embracing all ethical doctors of medicine without regard to race or creed. This resolution was conveyed to component societies by letter.

Resolutions 43 and 44 were disapproved by the House.

Substitute Resolution 46 directed development of a continuing program of acquiring medical identification items and making them available to physicians at no cost, upon request, for distribution to patients, and also the publicizing of such devices at the Michigan Health Fair.

This matter was referred to the Public Relations Committee. In implementing the recommendations of the House, all MSMS members were sent samples of the medical identification material with a covering letter inviting physicians to order supplies for distribution to their patients.

The recommendation regarding the Michigan Health Fair will be implemented at the proper time.

Resolution 48 directed initiation and maintenance of a program to publicize the harmful effects of cigarette smoking, and to promote an education program, particularly in schools and homes, to keep young people from starting the habit of smoking.

This matter was referred to the Cancer Control Committee which developed a plan for distribution of material on smoking and health for doctors' waiting rooms (through the Michigan Cancer Coordinating Committee). The Committee co-operated with and supported a pilot program of developing teaching manuals for use in Michigan schools. (See Annual Report of the Cancer Control Committee for details.) The Council also supported a Michigan Department of Health budget request for an educational campaign for youngsters, which failed of passage.

Resolutions 27 and 29 on this same subject were disapproved by the House.

Resolution 49 was withdrawn by the introducer, and the House recommended no action on Resolution 50.

Resolution 51 recommended that hospital staffs and psychiatric associations in Michigan make liberal use of psychiatrists in a consulting capacity. This resolution is presently under study by the MSMS Committee on Mental Health.

Resolution 52 instructed Council support of federal legislation to amend the Internal Revenue Code to provide for deductions of premiums of prepaid health insurance by any taxpayer for himself or his legal dependents. The Council transmitted the sense of the resolution to Congressmen.

Resolution 53 commended the Kent Medical Foundation and Joseph R. Lentini, M.D., for conducting the May, 1963, Health Fair. This resolution was transmitted by letter to Doctor Lentini and to the Kent County Medical Society.

Resolution 54 commended Joseph C. Foust, M.D., of Ionia, for his humanitarian work in East Africa. This resolution was transmitted by letter to Doctor Foust.

Resolution 56, authorizing the Michigan Health Fair, was referred to The Council for implementation. The Council has delegated development of details to the Committee on Arrangements for the Health Fair.

The House recommended no action on Resolution 59.

Resolution 62 recommended election of a delegate to the MSMS House of Delegates from each of the presently authorized and established specialty sections of MSMS. The House recommended that an ad hoc committee be appointed to study the whole section structure, including definition of qualifications for membership in the diverse sections, and referred this resolution to such a committee for study. (See Report of Ad Hoc Committee to Study Section Representation in House of Delegates).

Resolution 63 recommended that The Council consider development of a code establishing guidelines for the function of liaison committees of component societies with the pharmaceutical profession. This resolution was referred to the Liaison Committee with the Michigan State Pharmaceutical Association. (See Annual Report of this Committee).

Resolution 65 directed that every member of hospital boards of trustees be informed of the MSMS position that each hospital board should have one or more physician members.

At the direction of the 1962 House a letter was sent to the chairman or president of Michigan hospital boards of trustees urging appointment of M.D.s to the board.

The Council was faced with the question of how to implement this 1963 resolution since no list of hospital board members is available from any state or national organization. The question of possible methods of implementing Resolution 65 was referred to the Hospital Relations Committee for advice.

Resolution 66 recommending MSMS support of University Hospital at Wayne State University, was not acted on by the House. The House requested that this resolution be referred back to Wayne County Medical Society with the recommendation that specific action be taken by WCMS and a report brought back to the next session of the House of Delegates. This instruction of the House was communicated to Wayne County Medical Society.

Resolution 68 recommended that Michigan Medical Service be advised that participating and non-participating physicians should be treated alike.

Michigan Medical Service, under the terms of the consent judgment of the court, was obliged to take action contrary to the intent of this resolution (effective December 1, 1963).

Resolution 71 endorsed Governor Romney's plan for fiscal reform. No further follow-through was indicated.

Resolution 72 commended Otto K. Engelke, M.D., for his work as chairman of the MSMS Legal Affairs Committee. No further follow-through was indicated.

Resolution 73 was disapproved by the House.

Resolution 74 was disapproved by the House.

Resolution 75 recommended appointment of a committee to study the present procedures of the House of Delegates. Such a committee was appointed and will present a report to the House of Delegates. (See Annual Report of Ad Hoc Committee to Study Procedures of the House of Delegates.)

THE REFERENCE COMMITTEE on Reports of Officers, Robert M. Bookmyer, M.D., Chairman, commended the Speaker for his brief remarks which do not reflect the time devoted to this position. The Committee also noted the Speaker's review of the implementation of resolutions from the 1963 House of Delegates.

THE HOUSE adopted the report of the Reference Committee.

6. President's Address—Orlen J. Johnson, M.D.

Speaker Lightbody, Officers of the Society, Vice Speaker Hayes, Delegates and Guests:

Two years ago, from this podium, I expressed the wish that tonight and twenty years from tonight we remain a united, free profession in order that we could continue to give the greatest and best medical care in the world.

The two intervening years have been full, very gratifying and educational. As a mere unit in the organization I have seen The Council, committees and the staff meet

and work on matters before them with renewed effort. You will find in The Council and committee reports projects and plans for programs which manifest increased leadership by the Society. They are evidence of much thought and work by physicians to bring the best medical care to the people of Michigan. All fields—postgraduate education, the Journal, membership and the rest—are being updated.

The seemingly inexorable movement of politicians and socialists which would enslave the American public in the Great Society demands cohesive action by the medical profession. There was a front-page statement by Michigan's senior senator that the 1964 medicare bill lays down a principle which can be broadened later—and broadened it will be if it is once established.

The issue of government in medicine is not dead. When, and the direction this program will take, are uncertain; but it will always be with us.

Effective increased action can be attained only by physicians in every county and state. This will need expanded medical society organizations, as experience has shown many times.

For this purpose, the American Medical Association has under consideration a rather marked increase in dues. A report will be given to its House of Delegates in two months. Few can question the effectiveness of the American Medical Association in education, science and organizational activity. Equally or more important is the need for expanded state and county society activity. This requires added financing. I would not be so bold as to recommend doubling dues, but provision should be considered for increasing our staff activity. The study of MSMS organization and program the first of this year, plus our visits to county societies, make this apparent.

Study of the experiences in other countries as well as here shows that we must make an increased effort in legislative elections, both national and state. Fundamental preparation to establish arrangements and programs for equitable consideration of medical services and participation is a must.

In Michigan, the 1959 Fee Schedule for Governmental Agencies is a poor minimum—yet it has not been adopted in all counties. There can be do doubt that local government administration is more efficient, less costly and desirable.

The pattern of local determination was set in the Kerr-Mills Act. Let us preserve it. Remember, the broadened programs espoused by the socialists are not for welfare or indigent patients. They are for people who have been and actually still are able to obtain their medical care. Recognition of these facts is fundamental in dealing with these programs.

During several years of working in this organization, many times there has been confusion from action by this House of Delegates. In some instances it was difficult to determine the intent of resolutions as passed, or they could not be implemented, or they were too restrictive. Since this is the policy-making body of the Michigan State Medical Society and it meets only once a year, it is my considered and respectful opinion that the Society work and functioning of The Council would be enhanced and the leadership of the House greater if the deliberations of the House were confined for the most part to the establishment of policies rather than to the listing of specific procedures to implement policies.

It has been my privilege and duty to visit other houses of delegates of other state medical societies, and in many of them it is the policy of the House that resolutions be introduced early enough so that they can be printed and the delegates can study them and take them to their constituent society prior to their deliberations. There has been a resolution introduced which would require this of your House of Delegates, and I suggest that you seriously consider such a procedure. It is not a handicap to your deliberations, but rather would add greatly to the effectiveness of your actions.

Oliver McGillicuddy insisted that I tell you what a good President-elect he has been. [*Laughter*] Without having my arm twisted off, I shall tell you that he has been of great help. He is serious, he is interested, and whenever called upon he has responded. I think you can look forward to a great deal of effort on his part to serve the purposes of his office in the Michigan State Medical Society in his coming administration.

I am sure you are all aware that the work of this Society takes considerable time, and I would like to express my appreciation to my wife for her consideration and devotion to the practice of medicine. She has been a great help.

Fortunately for you, I have had the outlet of the President's Page and the opportunity to make a few speeches, so my verbosity is reduced today. However, I commend the study of Michigan State Medical Society organization and activity made by our staff and Professor Hardwick. I have been astounded by the energy, efficiency, loyalty and ability of the headquarters staff. Their assistance to me, to The Council and to the medical profession has been outstanding. To them all I am grateful.

I cannot pass without mentioning the great services that have been rendered to this Society and to the public and to medical education by John Sheldon. You have a resolution on this. It is with extreme regret that he will be unable to continue to contribute so much to medicine. It is even more regrettable that we have the condition which requires his withdrawal.

Special tribute should be paid to those members of the Michigan State Medical Society who devote to the medical profession and this organization endless hours of their great ability. This contribution by physicians to their profession and the public has been the highlight of my great experience as President.

Thank you very much.

THE REFERENCE COMMITTEE on Reports of Officers, Robert M. Bookmyer, M.D., Chairman, noted the President's remarks reflected a small portion of the time Doctor Johnson has spent in leading the MSMS to a successful year, and recommended that the House take due cognizance of the daily dedication of President Johnson during his time in office.

THE HOUSE adopted the report of the Reference Committee.

7. President-Elect's Address—Oliver B. McGillicuddy, M.D.

Mr. Speaker, President Johnson, Mr. Vice Speaker, Mrs. Himmelberger, Mrs. Brandis, Members of the House of Delegates and Guests:

As President-elect of the Michigan State Medical Society I address you today, proud of this honor and humbly aware of the fine attributes of my predecessors. Of these, our President, Orlen J. Johnson, has set a precedent that will be difficult to emulate. He has made splendid contributions to our Society and has given most conscientious devotion to his duties. I hope I can do as well.

Your Michigan State Medical Society is one of the finest state societies in the American Medical Association. It has innovated many firsts, but it has been on occasion slow to adopt some meritorious policies of other states.

Many states have adopted a judicial plan to complement their legislative House of Delegates and administrative Council of Trustees.

I see three phases of jurisdiction for a high-level Judicial Council or Board in Michigan: Ethics and mediation, grievances between patient and doctor, and utilization.

First is the problem of ethics and mediation. No group of people in the world have a higher sense of the lofty plane of ethics than doctors. However, there are exceptions in our ranks who damage the image of medicine and hurt all conscientious physicians. Most of these detractors can be controlled and disciplined on the local level, but occasionally a strong State facility should be available.

We have had an excellent Ethics Committee for years, but many problems referred by county medical societies and their members to the State are handled by the Chairman of The Council and our Legal Counsel. It is my opinion, having tried to settle some of these problems in the past, that an informed Board, with the advice of Mr. Dodd, could have arrived at a much more definitive and satisfying solution. Too many of these serious conflicts between doctors or between doctors and their county so-

cities have been swept under the rug with neither party being satisfied.

This House of Delegates recognized the need in Resolution No. 3 presented last year. This resolution, advocating a Disciplinary Board with strong powers, was referred to The Council for study. The Council in the intervening year has been very much concerned with this resolution. It has been studied by our Legal Affairs Committee and by Legal Counsel Lester P. Dodd. They concluded that it would be unconstitutional for such a body, elected by the House, to have the authority suggested in the resolution.

The Legal Affairs Committee concluded, on the basis of this legal advice, that the power, such as cancelling a license to practice of an errant doctor, would have to remain with the State Board of Registration in Medicine. They expressed the opinion, however, that the efficiency of the Board of Registration in these matters would be greatly enhanced by an adequate budget approximating the amount of monies now collected from M.D. registration, much of which now goes to the General Fund of the State.

My conception of a State Judicial Board is not so much one of discipline but of arbitration. Smaller county societies are particularly in need of an agency which will arbitrate disputes between doctors, between doctors and their county societies, and between doctors and their hospitals. The close familiarity of the contendents in these areas often makes impartial solution impossible.

Secondly, there are the patient-doctor grievance problems. Certain large county societies, notably in Arizona and California, have achieved commendable public relations in their much-publicized Grievance Committees. In these plans, both patient and doctor sign legal documents to the effect that the parties will abide by the decisions of the Committee. If the Committee finds the doctor is at fault, they insist on compensation to the patient in cases involving malpractice. In fee disputes they may find that the disputed fee is reasonable or that it is too high, or occasionally they may be recommend that it be cancelled.

If they find the doctor to be in the right they assure him of their complete support, and in these counties malpractice suits that reach court have greatly decreased in number.

These are large county grievance committees, but many states have augmented them with judicial councils or boards to arbitrate cases referred by county societies. I feel that Michigan needs such a board.

There are those who will be vocal in disagreement, those who will claim this sort of Board is an admission that the medical profession is a conscience-stricken group riddled by guilt obsessions and grovelling in its attempt at placating its discreditors. This, I contend, is not true, but rather that such a Board is further evidence of our determination to give the public honest medical care of the highest quality, and that we are on record as insisting on this quality.

Third is the problem of increased utilization. Quoting from the report of the Commission on the Cost of Medical Care: "During the past decade there has been a growing realization that a continuance of the American system of private practice is dependent, in a large measure, on the success or failure of voluntary health insurance and other prepayment mechanisms."

The many variations of utilization abuse, not only of Blue Shield but of commercial insurance, which require a State-level Board for arbitration, warrants as dignified and dedicated a court as we can muster. The solutions are not easy but many states have already established tribunals with very real disciplinary powers.

These utilization abuses range from outright fraud (a small percentage) to innocent, but perhaps unnecessary, over-use of insurance.

A recent Blue Shield directive states: "The frequency of services for providing care under the Michigan Blue Shield contracts has been increasing at the rate of 11 per cent a year or a three-year composite of 35 per cent, with a one-year cost increase of $6.2 million." This for approximately the same insured persons.

Quoting again from Blue Shield: "This may constitute good quality of care, but it is the duty of the Michigan State Medical Society and Michigan Medical Service to carefully study the problem and evaluate it."

There have been expressions that this is Blue Shield's problems; but actually commercial companies are as concerned, and you know who is being blamed for increased medical costs.

This is primarily a problem for local utilization committees. A State Judicial Board would function in an advisory capacity with perhaps district subcommittees to aid in the study of this problem.

Without presuming on your prerogative, this Board might consist of ten doctors elected by you for three-year staggered terms, or perhaps nominated by the House and elected by the membership of the Michigan State Medical Society, perhaps one doctor from each two combined Councilor Districts, three from Wayne County.

This would require changes in our Bylaws, substituting the Judicial Board for The Council wherever designated in Chapter VI, and for the State Ethics and Mediation Committee, which would be discontinued. Its duties in grievance and utilization would have to be spelled out.

Then, it would be my hope that, having established itself as a serious, studious body, the day might come when the State Legislature would grant it immunity from libel and might eventually endow it with authority similar to that now so effective in the legal profession's Committee on Grievances.

This Board, if adopted, should be autonomous and not dependent on The Council, and only responsible to the House of Delegates for its election.

Such a judicial body when duly elected would consider matters referred to it by county societies, and would stand ready to arbitrate problems of ethics and mediation, grievances and utilization, and possibly later discipline.

It would also be available for individuals appealing from a county medical society decision or inaction.

If this sounds like too much dictatorial power, reflect that we owe the people of this State no less.

This House of Delegates may well find it impossible or impractical to change the Bylaws and determine the minutia of such a Board at this session.

I would suggest that this House of Delegates approve the principle of a Judicial Board and authorize the establishment of a Judicial Commission, appointed by the Speaker or President of the Michigan State Medical Society, to prepare recommendations providing for a permanent Judicial Board and system to become effective following the 1965 Annual Session of the Michigan State Medical Society.

In the coming centennial year of organized medicine in Michigan, I implore all of you to use your considerable influence to advance the prestige of the Michigan State Medical Society.

I am cognizant of the honor you have paid me, determined to justify your trust, and thrilled by the opportunity of serving this fine organization.

THE REFERENCE COMMITTEE on Reports of Officers, Robert M. Bookmyer, M.D., Chairman, noted the speech of the President-Elect revealed a keen awareness of the problems facing physicians and agreed in general with his recommendations as to the establishment of a Judicial Commission. (No further action was taken on this matter since a resolution on the Judicial System had been introduced.) The House was urged to take due cognizance of Doctor McGillicuddy's devotion and splendid work during his term of office.

THE HOUSE adopted the report of the Reference Committee.

8. Report of Michigan Delegates to American Medical Association—Wm. A. Hyland, M.D., Chairman

Mr. Speaker, Members of the House of Delegates, and Friends of the Michigan State Medical Society:

This report, which is in your Handbook, covers 45 pages and is divided into three parts: First, the report of the House of Delegates of the AMA; second, the report of a portion of the scientific session; third, the final report of the Communications Committee on the AMA.

Mr. Speaker, in my allotted time I would like to hurriedly run over portions of the Communications report.

I would also call to your attention that a possible raise in AMA dues was discussed. This was deferred on motion

of Dr. Don Sweeny until the Board of Trustees could further study the necessity and outline more specifically some of the needs for such action and report to the House at its meeting next November and December in Miami.

The Communications report has recommendations of studying the possibility of some manner of the Executive Office of the American Medical Association being in closer touch with state and county societies in order to have at least overnight contact, informing these offices of important decisions and answers to questions that are of national and immediate import. This will not be expensive and should require no or very little increase in dues.

You all are no doubt aware of the Executive Office of the American Medical Association endeavoring early this month to obtain time on the three major television outlets for announcements relating to its stand on medical care. I quote a bulletin from the American Medical Association of September 8 last:

"TELEVISION NETWORKS DENY TIME TO AMA DRIVE

"The three major television networks—NBC, CBS and ABC—have refused to sell time to the American Medical Association for a series of one-minute commercials opposing the Administration's Medicare Plan now before Congress.

"Network spokesmen said such a sale would violate a long-standing policy of refusing to sell time by the minute for discussion on controversial issues, except for political commercials during an election campaign.

"Hits Network 'Censorship'

"Dr. F. J. L. Blasingame, Executive Vice President of the AMA, said the Association's campaign is intended to inform the public about free health care already available to the elderly who cannot afford to pay. He accused the networks of censorship of 'the people's right to know what is available to them.'

"He said the educational program is not intended to influence congressional action on pending legislation, since it is not to begin until October.

" 'By then Congress will have disposed of Medicare legislation and adjourned. If the controversial Medicare tax proposal is mentioned in our program, it will only be for the purpose of showing that such proposals are unnecessary because of the generous benefits existing under the Kerr-Mills law and other state and local health programs. We simply want to give the undeniable facts about the programs available.'

"Planned for 'Health Week'

"The AMA project is scheduled to coincide with the observance of Community Health Week, October 18 to 24. The AMA has engaged Fuller, Smith & Ross, advertising agency, to handle the television phase of the campaign, which would also utilize the newspapers and radio. A spokesman for the agency said the AMA would attempt to place the advertising on local TV stations in various cities.

"The AMA will rely on state and local medical societies to promote its health plan. Pamphlets will be distributed to the public. A 30-minute TV production is also in preparation."

(End of Bulletin)

The American Medical Association plans to spend about one million dollars in reaching the people through this type of medium, as a recent survey stated the American Medical Association's position on Medicare had made a much greater impression and won more comments during the last few months than at any time during the last several years—the feeling being that the people are really becoming more aware of what it is all about.

I would be remiss if I did not add my deepest appreciation to all the delegates from the Michigan State Medical Society to the American Medical Association for their at all times intense interest and covering all phases of the House reference groups and excellent discussion and advice. The group attended and discussed at many reference conferences a great number of the resolutions presented.

I would also like to include the Michigan State Medical Society officers and executive staff for their co-operation.

With appreciation also to the Michigan State Medical Society House of Delegates for allowing us to serve you, this report is respectfully submitted.

Thank you.

THE REFERENCE COMMITTEE on Reports of Officers, Robert M. Bookmyer, M.D., Chairman, reported: "This Reference Committee feels that the Michigan State Medical Society has had excellent representation at the American Medical Association Session. We pay tribute to our delegates for the time and effort expended in our interests. It is the feeling of this Reference Committee that the Delegates acted in our best interests, guided by the knowledge and experience of the medical and political talents of the American Medical Association.

"Your Reference Committee wishes to express its approval of especially two committees of the American Medical Association. The Reference Committee wishes to commend Dr. Hyland for his work as Chairman of the Communications Committee. His recommendations to the AMA will be discussed at Board level and then the recommendations will be referred back to the AMA House of Delegates.

"The Reference Committee also wishes to express its approval of the excellent work done by the AMA Council on Medical Service in the Report on Physician-Hospital Relations, June, 1964, and this Reference Committee recommends that this Report be made available to all hospital administrators in the State of Michigan by the executive office of the Michigan State Medical Society."

THE HOUSE adopted the report of the Reference Committee.

9. Report of Michigan Medical Service—Sidney Adler, M.D., President

(Mimeographed copies of the Summary of the MMS Annual Report and Supplementary Report were distributed to the Delegates.)

Before proceeding with my formal remarks, I would like to thank President-elect McGillicuddy for his most sincere and timely remarks regarding utilization. He has outlined the problem with candor and determination. To Dr. McGillicuddy and to this House of Delegates the Michigan Medical Service pledges every resource and every ounce of energy at its command. I am confident that together we can and will find meaningful answers to our problems.

One year ago, when Michigan Medical Service came before this House of Delegates, we were concerned about our financial stability. Today I am proud to report to this House of Delegates that Michigan Medical Service is in the best corporate condition in its 25-year history. Administrative costs are below the national average. The number of participating physicians has increased. Service benefits are at an all-time high. Claims are being handled more accurately. Our professional relations continue to improve. Our political and public relations scars are healed. Our fiscal position was never better.

Today's report concerns two items: (1) the Motor Negotiations, and (2) the New York State Department of Health Medical Audits.

1. The Motors Negotiations

The medical care as written at the bargaining tables by the UAW-CIO and Chrysler Corporation is as follows:

(1) Under nervous and mental benefits, inpatient services have been extended from 30 to 45 days.

(2) A psychiatric care program has been adopted to include services rendered in physicians' offices, night and day care centers, and the outpatient department of hospitals. These benefits are for service based on each hour or half hour of therapy, the maximum liability per patient being $400 per year. Included are variable contributions by the subscriber, depending on the number of visits.

(3) Hospital and professional services have been provided in facilities other than acute general hospitals; these include nursing and convalescent homes. As you know, the American Medical Association has recommended that physicians participate in area-wide planning in all these types of institutions. Fees to physicians will be covered in these institutions.

(4) In obstetrics, pre- and postnatal care have been included for subscribers.

(5) The 270-days' waiting period in obstetric cases will be waived and immediate maternity will be provided as a benefit for new hirees.

(6) Class II deductibles will be waived for services rendered on an inpatient basis.

(7) Coverage will be extended to all dependents up to age 25 who meet the eligibility requirements of our family continuation program and to children totally disabled at any age who meet certain eligibility requirements.

We anticipate the story will be substantially the same at the Ford Motor Company and ultimately General Motors Corporation.

The above scope of services will not become effective until September, 1966. This gives the medical profession time to analyze all aspects of this program. The Board of Directors of Michigan Medical Service has not yet had an opportunity to review the program. I report this to you for informational purposes only.

2. *New York Medical Audits*

Ten days ago I was visited by physicians representing the New York State Department of Health. They wanted Michigan Medical Service's ideas and help in developing methods to study and analyze the frequency-of-use patterns.

They told us that the New York Legislature had passed a law in 1963 ordering the State Health Department to investigate utilization. I will read that section of the law pertinent to this discussion:

"Make such scientific studies and research which have for their purpose the reduction of morbidity and mortality and the improvement of the quality of medical care through the conduction of medical audits within the State.

"In conducting such studies and research, the Commissioner is authorized to receive reports on forms prepared by him, and the furnishing of such information to the Commissioner, or his authorized representatives, shall not subject any person, hospital, sanitarium, rest home, nursing home, or other person or agency furnishing such information to any action for damages or other relief.

"Such information when received by the Commissioner or his authorized representatives shall be kept confidential and shall be used solely for the purposes of medical or scientific research or the improvement of the quality of medical care through the conduction of medical audits."

For your information, the New York representatives said their audits were just getting under way.

They said the medical audits will be done both in and outside the hospital.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, James B. Blodgett, M.D., chairman, recommended acceptance of the summary of the annual report presented to the House by Doctor Adler, and commended Dr. Adler for his continuing fine service to the people (House Amendment: "and the physicians") of Michigan through Michigan Medical Service.

THE HOUSE adopted the report of the Reference Committee as amended.

10. Report of Woman's Auxiliary to Michigan State Medical Society—Mrs. R. J. Himmelberger, President

Speaker Lightbody, Officers of the Society, Vice-Speaker Hayes, Delegates and Guests:

It is a real privilege to come before you today and to tell you in a few words of our activities during the past year. My complete report is printed for you to read.

Today we have a membership of approximately 3,201, which is about half of our potential membership. There are forty-three organized counties.

Our program is diversified and geared to the needs of the community. Our AMA-ERF Chairman is a very alert and hard-working woman. Our contribution to the AMA-ERF National Fund was $16,312.84, an average of $4.99 per member, with only 80 per cent of the counties participating.

Mental health has played a big part in our program. Many counties assisted in programs in hospitals and training centers for handicapped children. The Auxiliary made itself available to the Michigan Department of Mental Health for volunteer work as administrative assistants in the current planning program for mental health and illness.

The International Health Committee reported astounding results, with thousands of pounds of sample drugs sent to World Medical Relief and other organizations, and many thousands of pounds of equipment was sent to establish hospitals and clinics throughout the world. All of this was made possible through the cooperation of the doctors and the medical assistants.

Recruitment in health careers has continued as one of our major projects, and many scholarships and loans are offered.

Much has been said about driver education and seat belts, safety in the home and on the farm, as well as on the highway. We have been asked to become a member of the Woman's Division of the Michigan Safety Conference. This is the 22nd year we have participated in the tuberculosis and respiratory disease speaking project, and over 3,000 students participated in this project.

We have accomplished this and much more with less than half of our potential membership. You may be tired of having us ask you to go home and ask your wives if they are members and, if not, why not, and urge the county society to see the need of increasing the Auxiliary membership. We need your help.

I want to thank the Auxiliary officers, chairmen and members for their help and a job well done. I also want to thank the State Medical Society and the Advisory Committee for all the assistance they have given the Auxiliary, and especially the assistance they have so graciously given me.

Thank you.

THE REFERENCE COMMITTEE on Reports of Officers, Robert M. Bookmyer, M.D., Chairman, reported: "This Reference Committee thanks Mrs. Himmelberger for the report of her activities as President of the Auxiliary. We recommend to the House that a strong plea be made to members of component medical societies to encourage membership of their spouses in this organization.

We admire the Auxiliary's excellent contribution of almost $16,500 to the American Medical Association Education and Research Foundation. We commend them on their work in Operation Home Town, the International Health Committee and their volunteer work in mental health, TB and respiratory disease projects, and their work with the Student Auxiliary of the American Medical Association. We wish them success in their recruitment program in the year to come.

THE HOUSE adopted the report of the Reference Committee.

11. Report of the Michigan State Medical Assistants Society—Mrs. Dorothy Brandis, President

President Johnson, Speaker Lightbody, Delegates and Guests:

Good morning. It is my privilege to extend greetings from the Michigan State Medical Assistants Society.

Activities

The Seventh Annual Convention of the American Association of Medical Assistants was held in Miami Beach, Florida, in October 1963. Michigan was represented by four delegates and two alternates, additionally 22 Michigan members were in attendance and Dr. Glenn E. Millard, Chairman of our Advisory Board and Mrs. Millard. Seven members took the certification examination preceding the convention.

In November, a workshop was held for county officers and committee chairmen in Mt. Clemens with an attendance of 73.

The Michigan State Medical Society County Secretaries Conference was attended by four representatives in February.

The Seventh Annual Educational Seminar was held in Detroit in March with an attendance of 197. Lectures included, the L. Fernald Foster lecture by Helen Nutting, M.D.; Women in Wall Street by Mrs. P. Breen; and Women's Role in the World of Medicine by Viola Brekke, M.D.

Instituted this year was an Educational Seminar in the Upper Peninsula for medical assistants. This was held on July 11-12 in Marquette. Sixty-eight members, non-members and guests were in attendance including T. J. Trapasso, M.D., U.P. member of Advisory Board.

The Fifteenth Annual Convention will be held this week at the Statler-Hilton Hotel, Detroit and the Michigan State Medical Assistants will have their first meeting of a House of Delegates. This will be composed of 95 delegates representing 24 counties. Speakers for the Convention are: A. E. Heustis, M.D., R. J. Lukens, M.D., Rev. Dr. Paul B. McCleave, American Medical Association, and Edgar A. Guest, Jr. We welcome your attendance.

The Eighth Annual Meeting of the American Association of Medical Assistants will be held in October in Oklahoma City. Four delegates and two alternates will represent Michigan. Michigan is sponsoring a candidate for the national office of Secretary-Treasurer.

We will again honor a medical assistant of the year.

Two new membership brochures were mailed to all physicians' offices and three special flyers were mailed during the year.

Bulletin

The Bulletin has a new format and all issues have been printed and sent to our membership. We are very proud of our *Bulletin* and we hope that in the near future sufficient advertisers will make it self-supporting.

Membership

Total membership as of June 30, 1964: 918

Education

The educational programs continue in seven areas for in-service training. The Michigan State Medical Assistants were requested to serve on the Advisory Committee for the Ferris State College and for the Government re-training program at Highland Park Jr. College. Flint Jr. College has also requested our assistance in setting up a course for medical assistants.

Legislation

We have remained very active in supporting the Michigan State Medical Society's request to prod our bosses, friends and patients and to individually write Congressmen opposing the King-Anderson Bill. All members of our organization were contacted to support your revisions to Senate Bill 1056.

Conclusion

Following the annual meeting in September, the various activities of our Society got underway. Our previous requests for closer liaison between the Michigan State Medical Society and the Michigan State Medical Assistants Society has been accomplished including our request for office space at your headquarters. Mr. Ralph Wills was appointed as liaison and has worked very closely with our Society.

We shall make every endeavor to show our appreciation for the privilege of being associated with the Michigan State Medical Society and assure you of our continued cooperation. We shall make every effort to continue striving to provide the best educational opportunities for all medical assistants, to promote public relations, and we have not, and we will not, let our Society become a trade union. We thank you for the office space, the use of facilities for our board meetings and we especially thank Doctors Millard, Green and Trapasso for their counsel and continued guidance.

We welcome you to attend any or all of our meetings at the Statler-Hilton Hotel on Wednesday and Thursday of this week.

THE REFERENCE COMMITTEE on Reports of Officers, Robert M. Bookmyer, M.D., Chairman, reported: "We note with gratification the continuing growth of this organization. We also commend the education programs for in-service training. The Reference Committee feels this is a forward step in improving the caliber of this organization. The Committee also wishes to thank the Society for actively supporting the MSMS view on medical-political issues."

THE HOUSE adopted the report of the Reference Committee.

REPORTS OF THE COUNCIL

12. Annual Report of the Council

(See also, Remarks of Council Chairman)

PART I

Report of Council Activities

This section of the report contains a brief review of the activities and actions of the Council covering the period from September, 1963, to September, 1964.

Organization Activities

Headquarters Organization.—In September, 1963, The Council directed the new Executive Director, the new Associate Executive Director, and Professor Clyde Hardwick, MSMS Economic Consultant, to proceed with the development of organizational recommendations.

The Reorganization Study was prepared and presented to The Council, and was approved with commendation. The Study included: 1) Nature, Scope and Guidelines of Reorganization, 2) A Bold Look in the Future, outlining specific recommendations in eleven areas coinciding with the purposes of MSMS, 3) Reports on Staff Activity, Survey of Clerical and Secretarial Duties, Secretarial Job Classifications and Descriptions, Wage and Salary Survey, Survey of Personnel Policies, and 4) Conclusions of the Study and Tentative Assignment of Duties.

The Council is pleased to report that the new leadership team of the headquarters staff has functioned in a most dedicated and efficient manner. The realignment of staff duties and organization has facilitated the work of The Council, the House of Delegates and the MSMS committees.

Membership.—Total membership as of June 30 and as of December 31, from 1935 to 1964, is indicated in the following chart:

Year	*June 30*	*December 31*
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1961	6639	6775
1962	6776	7018
1963	6858	7137
1964	6954	

The membership comparison as of November 30, 1962, and November 30, 1963, indicates a gain of 119 members during the year with 91 of these in the active classification. Membership for the year ended November 30, 1963, grew at a rate of 1.5% equally distributed between exempt and active members. Total membership November 30, 1963, was 7137, Active 6173, Exempt 964.

Finance.—All Departments are being operated economically in line with fulfillment of the aims and purposes of the State Medical Society. All committees are maintaining their activities within their budget allocations. The reserve of $57,000 in Government bonds has been maintained with $35,000 of this amount earmarked for the Public Relations Department. The balance of $22,000 in bonds is for the General Fund.

In addition, a Savings Reserve account was established in 1963 and to June 30, 1964, $36,643.99 has been placed in this account at the Michigan National Bank. This account is retained as a liquid reserve for contingencies.

The financing of the headquarters building has been reported each year since construction began. On July 1, 1964, we had notes due in the amount of $10,000. However, as in the past, it will be necessary to reborrow during the closing months of the year (October or November) and repay in the early months of 1965 when dues income is high.

At the end of fiscal 1961, outstanding notes totaled $200,000.
At the end of fiscal 1962, outstanding notes totaled $150,000.
At the end of fiscal 1963, outstanding notes totaled $125,000.
At the end of fiscal 1964, outstanding notes *may* total $90,000.

Bylaws Provisions Regarding Dues for New Members.—The Bylaws now provide that MSMS may offer a dues reduction to new members first entering practice, providing

the component society also reduces its dues to new members. The question arises as to how this provision is to be interpreted if the component society has no dues. The Council refers this matter to the House of Delegates Committee on Constitution and Bylaws.

Death of William A. Scott, M.D., Councilor, Fourth District.—The Council with deep sorrow reports the untimely death of William A. Scott, M.D., Kalamazoo, who passed away on February 24, 1964. His leadership as Chairman of the Council's Publication Committee and in mental health activities will be sorely missed.

Procedure for Filling Councilor Vacancy.—Two vacancies occurred this year due to the untimely passing of William A. Scott, M.D., Councilor, Fourth District, and the resignation of Harold Kessler, M.D., Councilor, Tenth District.

The Council adopted the following procedure for filling such vacancies: "that the seated delegates of a Councilor District in which a vacancy occurs, either by resignation or death, shall caucus as early as possible to select a nominee for submission to The Council for appointment to serve as Councilor of that District until the next Session of the House of Delegates, when the unexpired term may be filled by members of the House."

This matter was referred to the House of Delegates Committee on Constitution and Bylaws.

Geriatrics Committee Name Change.—The Council approved the recommendation of the Geriatrics Committee that its name be changed to Committee on Aging, as suggested by the American Medical Association. This action has been referred to the House of Delegates Committee on Constitution and Bylaws.

Public Health Interim Committee.—At its 1963 session, the House of Delegates approved Council and Public Health Committee recommendations changing the purpose, scope and composition of the Public Health Committee. However, time did not permit House action to be translated into specific Bylaw amendments for House adoption.

Therefore, the MSMS President carried out the intent of the House and appointed a Public Health Interim Committee, according to the approved recommendation, to serve the intent of the House of Delegates action.

AMA Concept of Public Health.—In July, 1963, The Council reviewed the 1962 AMA Concept of Public Health and subsequently requested the AMA, by resolution introduced at the 1963 AMA Clinical Meeting in Portland, Oregon, to redefine this concept. The resolution was approved and referred to the AMA Board of Trustees for establishment of a definition. A Council committee continued its study which resulted in a new definition (see Annual Report of Ad Hoc Committee to Study AMA Concept of Public Health). In its report to the 1964 AMA House of Delegates in June, the AMA Board recommended no change in the AMA concept. MSMS will continue to seek a redefinition of public health through all appropriate channels.

Annual County Secretaries-Public Relations Seminar.—The 1964 Seminar was held February 27 at the Jack Tar Hotel in Lansing. Guests at the session discussed organization, postgraduate medicine, medical ethics, economics of practice, and public education. The component society leaders also heard a report on legislation, Operation Hometown, and an address from AMA Executive Vice President F. J. L. Blasingame, M.D. The annual MSMS Awards Luncheon was held at noon. (See Annual Report of Awards Committee.)

An innovation at this year's Seminar was the holding of meetings on the eve of the Seminar of the 1) Public Relations Committee; 2) Legal Affairs Committee; 3) Diabetes Committee; 4) Component Society Secretaries Workshop and 5) Component Society Bulletin Editors Workshop. Plans for enlarging this pre-Seminar activity for 1965 are under study by The Council.

Study of Honoraria for MSMS Officers.—The Council requested its Finance Committee to study the question of honoraria for officers who must devote an unusual amount of time away from their medical practice. This matter was referred to The Council for further study by the 1963 House of Delegates.

The Finance Committee surveyed the practices of other large medical associations.

In July, The Council adopted the following recommendations to the House of Delegates: 1) that the President, Chairman of The Council, and the Speaker of the House of Delegates be given a special expense allowance of up to $1,000; and further, that these officers be automatically elected to Life Membership in the MSMS upon completion of their term of office; 2) that all living past-Presidents, Chairmen of the Council and Speakers be given Life Membership in MSMS. An estimated twenty-eight past officers would be eligible under the proposed plan and the loss of revenue to MSMS would approximate $2,300 per year. (See Council recommendation in Part IV of this report.)

Financial Aid to Indigent Physicians.—The Council's Finance Committee is continuing its study of this subject, including the recent survey of need in Michigan and the information obtained from other state medical associations which have aid programs.

Workshops for Component Society Executive Secretaries.—Two workshops were held this year, in which the State Society and component society staffs were able to discuss mutual problems and goals and increase abilities to serve the membership.

Legal Matters.—Legal Counsel Lester P. Dodd has enjoyed a busy year. Approximately 50 written opinions were rendered and a larger number of informal opinions were given on a wide range of subjects regarding the activities of the Society and the interests of its members.

Mr. Dodd attended meetings of the House of Delegates, The Council, many committees and the Annual Session, Michigan Clinical Institute and Annual County Secretaries-Public Relations Seminar.

Advice of Legal Counsel was especially valuable to the Legal Affairs Committee and the House of Delegates Committee on Constitution and Bylaws.

As usual, Mr. Dodd has counselled with and advised officers and members of the staff in almost every facet of the Society's activities.

Relations—Professional, Public, Legislative and Prepayment Plans

General Liaison Activities.—The Council and its committees were involved in many matters concerning medicine, hospitals, state agencies and boards and liaison was maintained through individual physicians and staff. Also, liaison with lay organizations and voluntary agencies was accelerated during the past year. Extra effort is being expended to build better relations with the many organizations which are interested in or related to health and medicine.

Legal Affairs.—Detailed activities in the legislative arena will appear in the Annual Report of the Legal Affairs Committee. In brief, however, The Council was deeply involved in the policy decisions relating to the reorganization of state government, the State Board of Pharmacy, Michigan Crippled Children Commission, Michigan Department of Health and Michigan Department of Social Welfare.

Liaison with Osteopaths.—The House of Delegates and The Council each appointed a committee to study and act on this matter—the House of Delegates Committee to Study Relationships between M.D.s and D.O.s and The Council's Liaison Committee with Michigan Association of Osteopathic Physicians and Surgeons, Inc.

The Council believed that the work of the two committees would be benefited if the committees met jointly to consider the subject at hand. This they did on several occasions, meeting as the MSMS Joint Committee on Medicine and Osteopathy.

The Committees have provided vigorous leadership and are to be especially complimented for educational efforts at the Special Session of The Council on March 9, 1964, to

which were invited the members of the AMA Committee on Medicine and Osteopathy.

Medical Aid Station at Capitol Building.—In cooperation with the physicians of Ingham County Medical Society, a medical aid station was provided in the Michigan Legislature, staffed by a nurse. MSMS provided necessary funds and local physicians volunteered to provide necessary coverage for emergency or referred calls. The Council expresses its appreciation to the Ingham County physicians who participated in this important liaison project.

Annual Washington Visit.—As authorized by the 1963 House of Delegates, officers and staff visited legislators and their aides in Washington, D. C. Again, this was an effective and productive liaison meeting. The Council is pleased to note the increased activity of component societies in sending delegations to Washington.

Liaison with Michigan Health Council.—The Michigan Health Council continues to expand its Professional Placement Program. During 1964 it has been responsible in whole or in part for the placement of 71 doctors of medicine, 25 doctors of dentistry and six doctors of veterinary medicine.

The Health Council has promoted coordinated home care, and there are currently nine home care programs in operation in the state.

It has produced more than 100 television programs on health and medicine which have covered two-thirds of the state's viewing audience.

Its Health Careers Recruitment Program has continued to expand and this spring a special project of recruiting students into careers in the rehabilitation field was begun.

The Health Council has also worked closely with more than 70 school health councils and community health councils throughout Michigan. Many of these recruitment activities, health educational programs and several of the local health councils participated in Community Health Week in Michigan during October, 1963, which was jointly sponsored by MSMS, the Michigan Health Council and the Michigan Association of the Professions.

Operation Hometown.—Operation Hometown was designed as a nationwide intensive year-long program for each county medical society to help offset the pressure for King-Anderson legislation in the 88th and 89th Congresses.

The Operation Hometown campaign covered seven segments of organized activity, as follows: a) County campaign chairmen; b) Speakers bureau; c) Enlisting allies; d) Newspapers, radio and TV; e) Letter writing; f) Materials distribution, and g) Congressional contacts.

Presidents of county societies appointed Operation Hometown Chairmen to coordinate the work of the campaign in 38 of the 55 county societies.

Valued assistance was given by the Woman's Auxiliary and by the Michigan State Medical Assistants Society in distribution of materials to doctors' offices as well as in the letter-writing segment of Operation Hometown.

Liaison Committee with Michigan Hospital Service.—The Council requested the Board of Michigan Hospital Service to appoint members of its Board to a liaison committee to consider matters of mutual interest with MSMS, the committee to be composed of members of The Council and the Blue Cross Board.

The Blue Cross Board will consider this request prior to September.

Liaison Between Michigan Hospital Association and Michigan Medical Service.—The Council supported a resolution of the Michigan Hospital Association which requested that a committee be created with MHA and MMS representatives to provide continuing liaison between the two groups. In addition, The Council suggested that whenever feasible it be the policy of both organizations to discuss matters of mutual interest prior to the adoption of policies relating thereto.

Liaison with Michigan Association of the Professions.—MSMS has continued to profit by its liaison with the Michigan Association of the Professions. Its Annual Congress of the Professions, held each year in conjunction with the MAP-sponsored "Professional Week," presented several nationally known physicians and passed resolutions supporting medicine's policies in regard to both state and national legislation. Thirty-five doctors appeared on the television program "Decision—The Moment of Truth," (WJBK-TV, Channel 2, Detroit) which MAP co-sponsors with the Michigan Health Council. The recently launched one-half hour MAP television program entitled "Formula" WJIM-TV, Channel 6, Lansing) has featured several doctors of medicine and looks forward to continued participation and cooperation from MSMS members. Combined, the two weekly television programs are capable of reaching 90% of the viewing audience of Michigan. In addition MONITOR, official publication of MAP, carries information on MSMS to members of the other professions on a monthly basis. Several physicians have taken advantage of the MAP Pension Plan and Trust. This plan was made possible by the passage of the Keogh Bill and is the first such plan to be approved by the Internal Revenue Service in Michigan. MSMS joined with MAP in making recommendations to the Governor-appointed Citizens Committee on Higher Education regarding the needs for graduate professional education in Michigan. MAP-type organizations have been formed in several other states with effective support coming from the AMA.

Dissolution of Beaumont Memorial Foundation.—The Council was advised that legal obstacles to the dissolution of the Foundation had been resolved. Since the work of the Foundation had been completed, the corporation would be dissolved if MSMS would accept the minor assets and appoint a committee to oversee the operation of the project. The Council did accept this responsibility.

Reports of Michigan Medical Service.—At each meeting of The Council, the President of Michigan Medical Service presented a review of matters of mutual interest.

In addition, The Council met with the Board of Trustees of MMS in March to improve understanding and communication between the two bodies.

Reaffirmation of 1939 Agreement Between Representatives of Michigan State Medical Society and Michigan Hospital Association.—The following agreement, adopted on January 22, 1939, was reaffirmed by The Council and so reported to the Michigan Hospital Association and to Michigan Hospital Service:

AGREEMENT BETWEEN REPRESENTATIVES
OF
MICHIGAN STATE MEDICAL SOCIETY AND MICHIGAN
HOSPITAL ASSOCIATION

January 22, 1939

At a meeting in the Durant Hotel, Flint, Michigan, on January 22, 1939, attended by representatives of the Michigan State Medical Society and the Michigan Hospital Association, the following motion was made by H. A. Luce, M.D., President of the MSMS, and seconded by Ralph M. Hueston, President of the Michigan Hospital Association, and unanimously carried by those present, whose signatures are appended herewith:

"It is agreed that the professional services of a doctor of medicine shall not be included in group hospital service programs. Technical services may be rendered as hereinafter defined: Technical services in connection with hospital and medical service plans are not considered professional medical services unless rendered directly by a doctor of medicine. Notwithstanding the above definition, it is agreed that the hospital program will not include any x-ray service."

Signed—Henry A. Luce
Wm. J. Griffin
Robert G. Grive
Ralph M. Hueston
P. R. Urmston
L. Fernald Foster

Proposed Transfer of Professional Services to Hospital Service Benefits.—This problem has received the continuing attention of The Council and its Hospital Relations Committee (see Annual Report of this Committee for further details). The Council took direct action as did the Hospital Relations Committee.

The committee worked closely with the Michigan Society of Internal Medicine, Detroit Roentgen Ray and Radium Society, and its Western Michigan Division, Michigan Society of Anesthesiologists, Michigan Society of Pathologists and the Kalamazoo Academy of Medicine.

Postgraduate Education

Annual Session Section Speakers.—With the adoption of new programming of the Annual Session scientific sessions incorporating extensive use of panel presentations, The Council restudied its policy regarding speakers for MSMS section meetings. The Council has authorized the payment of honorarium and expenses for a Section speaker at the Annual Session in those special cases where there is no speaker participating in the General Session program who is a representative of a section's specialty.

Centennial Annual Session, 1965.—The Michigan State Medical Society will celebrate its centennial year beginning in September, 1965. The Annual Session will be held in Cobo Hall, Detroit. In order to focus on this outstanding event, the Michigan Clinical Institute will not be held in 1965. Also, the Michigan Academy of General Practice has agreed to hold no annual meeting in 1965 but will arrange, as part of the MSMS Annual Session, a one-day program to be known and publicized as MAGP Day. (See Annual Report of Committee to Coordinate Meetings During Centennial Year.)

Co-Sponsorship of Conference on Diet Therapy.—For the second year MSMS and the Michigan Department of Health co-sponsored a two-day Conference on Diet Therapy with the cooperation of Wayne State University School of Medicine and the University of Michigan Medical School.

1964 Michigan Clinical Institute.—Special effort was devoted to this last MCI in order to make it a memorable event in both quantity and quality of scientific education. The Council happily notes that attendance of M.D.'s at this meeting increased 10% and overall attendance increased 15% over the 1963 session.

Though the MCI will no longer be produced, the Postgraduate Medical Education Committee is studying new methods of increasing MSMS postgraduate programs throughout the state.

1963 Annual Session.—This meeting, held in Grand Rapids, was the first MSMS scientific assembly to adopt the new panel-presentation format. The meeting was enthusiastically received and attendance surpassed the previous Grand Rapids session by a significant number.

The Journal of MSMS. The year 1963-64 will be remembered as the "year of change" for the MSMS Journal as the Publication Committee and The Council seek to make the monthly publication more effective. Briefly the changes included:

—Following the death on July 12, 1963, of Wilfrid Haughey, M.D., Editor, The Council appointed C. J. Tupper, M.D., Ann Arbor, as Scientific Editor.

—Following the death on February 24, 1964, of William A. Scott, M.D., Chairman of the Publication Committee, The Council elected B. M. Harris, M.D., to fill that chairmanship.

—The position of Managing Editor was established and Herbert A. Auer, of the staff, was chosen.

—The name of the publication was changed in July to "Michigan Medicine, The Journal of the Michigan State Medical Society."

—There were 23 other changes in content and format made in the July issue to further improve the readability and impact of the publication.

—The former custom of devoting an entire issue to one phase of medicine was discontinued and now each monthly number contains carefully chosen scientific papers of interest to a wide cross-section of the membership.

—To offset the continuing decline in national, pharmaceutical advertising, a Michigan publishers representative has been secured on a commission basis to contact Michigan firms for advertising.

Conversation, communications and requests from other publications to reprint MSMS articles all indicate that the changes have been well received by the membership. Further refinements are planned to enable "Michigan Medicine" to serve as both vehicle for postgraduate education and as a house organ for MSMS.

Ethics and Standards of Practice

Question of Ethics in Cases Where Physicians' Prescription Blanks Carry Printed Advertising of Pharmacies—The Council refers this ethical question to the House of Delegates for consideration. (See Council recommendation in Part IV of this report.)

Development of Model Judicial System.—With the full cooperation of the AMA Legal Department, The Council has authorized the study and development of a model judicial plan to provide the best possible handling of ethical, mediation and other appropriate related matters. The study is underway and progress will be reported to the House of Delegates at this Session.

Medical Socio-Economics

Department of Medical Socio-Economics.—This year again confirmed the importance of this activity to the overall effectiveness of your State Society. Examples of this are its valuable contributions in terms of collecting economic data and providing original research to Council and other State Society committees which are faced with problems that carry socio-economic dimensions. The Department also completed a basic research project with the assistance of AMA regarding membership in medical organizations of all doctors of medicine in Michigan. Details of the work of the Department can be found in the Annual Report of the Committee on Medical Socio-Economics.

Revision of Michigan Uniform Fee Schedule for Governmental Welfare Agencies.—The Council appointed a committee to update the Uniform Fee Schedule previously revised in 1959. The committee has been informed of the desire of the House of Delegates and of The Council that the fee schedule be based on the policy that wards of government be not treated as indigents and that physicians be compensated by their average fee for services.

MSMS Insurance Programs.—

(a) Group Life Insurance:

Number of members now insured	1,440
Amount of insurance now in force	13,632,000
Premium collected during past year	159,513
Claims paid during past year	45,186
Members under waiver of premium, 6 for	52,500
Dividends paid for past year	24,794
(Above figures include 212 members who elected to replace term insurance with permanent)	

(b) "Family Plan" Insurance:

Number of members now insured	561
Amount of insurance now in force	11,070,000

(c) Group Disability Insurance:

Number of members now insured	1,986
Accidental death claims	1
Loss of time payments	437
Amount of payments	132,414
Average number of payments per month	37
Percentage of insureds receiving payment during past year	10.4%
Claim reserves	117,350

AMA Education and Research Foundation.—As part of 1963 MSMS dues, $10 was earmarked for AMA-ERF, to be returned to the two Michigan medical schools on a prorata student basis. At the January Seminar, a public presentation was made to the two deans of checks totaling $60,259.81 as the MSMS contribution. A formal presentation to AMA-ERF was also made before the House of Delegates of the American Medical Association at its Annual Session June, 1964.

MAA Rules Change Became Effective July 1, 1964.—Commencing July 1, 1964, county welfare departments are free to negotiate doctor (and hospital) rates separately from the rates paid in other state assistance programs.

This is made possible by the repeal on that date of Administrative Rule 10, adopted by the State Department of

Social Welfare at the onset of the MAA program, and providing that payments for services rendered under Medical Assistance to the Aged could not exceed payments made for similar services under other existing programs.

As a result of Rule 10's repeal on July 1, it is variously estimated that hospital reimbursements can now be negotiated upward approximately $320,000 per year, the difference between 75% and 100% of per diem cost, thus enabling the hospitals to accept MAA cases without financial hardship. The rule repeal will likewise permit negotiation of doctors' fees up to the full Uniform Fee Schedule, resulting in an aggregate increase in payments to physicians of approximately $225,000 per year.

On July 7, the Wayne County Board of Supervisors authorized payment of 100% of the Uniform Fee Schedule.

PART II

Annual Reports of Committees

The following Annual Reports of Committees in the Handbook for Delegates have been reviewed by The Council:

Committees of The Council.—
Committee on Alcoholism and Drug Addiction
Committee on Awards
Committee on Coordination of Medical Meetings During Centennial Year
Committee on Courses on Medical Economics and Ethics
Committee on Disaster Medical Care
Committee on Medicare
Committee on Nursing
Committee on Oral Polio Vaccine
Committee on Rehabilitation
Committee to Study Proposed Utilization Committee
Committee on Veterans Affairs
Liaison Committee with Cardiac Disease Control Committee re Financial Matters
Liaison Committee with Michigan Crippled Children Commission
Liaison Committee with Michigan State Board of Registration in Medicine
AMA Education and Research Foundation—Michigan Chairman
MSMS Committees.—
Advisory Committee of Past Presidents
Committee on Child Welfare
Committee on Iodized Salt
Committee on Legal Affairs
Committee on Maternal Health
Committee on Prevention of Highway Accidents

The following Annual Reports of Committees, in the Handbook for Delegates, will not be considered by The Council until its September 20 meeting. If there are any comments or recommendations The Council wishes to make regarding these reports, they will be transmitted to the House in the verbal report of Council Chairman Hiscock.

Council Committees.—
Committee on Health Fair Arrangements
Committee on Hospital Relations
Committee on Medicine and Religion
Committee on Medicine and Osteopathy
Committee on Relative Value Study
Liaison Committee with Residents and Interns
Committee on Retirement Plan
Liaison Committee with State Bar of Michigan
Liaison Committee with State Executive Office
Committee to Study AMA Concept of Public Health
Committee to Study Establishment of MSMS Service Corporation
Liaison Committee with Michigan State Pharmaceutical Association
Committee on Uniform Fee Schedule for Governmental Welfare Agencies
Committee on Workmen's Compensation
Joint Council to Improve Health Care of the Aged
Permanent Conference Committee
MSMS Committees.—
Committee on Cancer Control
Committee on Cardiac Disease
Committee on Diabetes
Committee on Ethics
Committee on Geriatrics
Committee on Medical Socio-Economics
Committee on Mental Health
Advisory Committee to Michigan State Medical Assistants Society
Committee on Occupational Health
Committee on Postgraduate Medical Education
Committee on Professional Insurance Plans
Public Health Interim Committee
Committee on Public Relations
Committee on Rural Medical Service
Committee on Scientific Radio and Television
Committee on Venereal Disease Control
Advisory Committee to Woman's Auxiliary

PART III

Matters Referred to The Council by the 1963 House of Delegates

Substitute Resolution for Resolutions 2, 35, 41, 57 and 58.—This resolution 1) directed the establishment of a Liaison Committee with the Michigan Crippled Children Commission, 2) recommended using services of hospital credentials committees in determining qualifications for elective surgery done under the afflicted children's program, 3) urged the MCCC to continue its efforts to revise and update its fee schedule, and 4) urged the MCCC to take steps to simplify its billing procedures.

The Council appointed a Liaison Committee which, at its meeting with MCCC representatives, urged the steps indicated above. (See Annual Report of Liaison Committee with Michigan Crippled Children Commission.)

With the help of the MCCC, the MSMS Economic Director and legislative staff, a new fee schedule was adopted by MCCC and approved by the Legislature, at 75 percent of the fees set forth in the MSMS Uniform Fee Schedule for Governmental Welfare Agencies.

Resolution 3.—This resolution recommended Council study of legislation to form a State Medical Disciplinary Board.

The Council referred this matter to the Legal Affairs Committee. A Legal Opinion was rendered and the matter referred to the Liaison Committee with the State Board of Registration in Medicine. The Board was appropriated additional funds by the Legislature to improve investigative functions of the Board.

The creation of a disciplinary board, under the terms of the resolution, is not possible under present Michigan Law. (See Annual Report of Liaison Committee with State Board of Registration in Medicine.)

Resolutions 13, 14, 15, 16 and 18.—These resolutions, which had to do with reorganization of state government, were referred by The Council to the Legal Affairs Committee. The Committee transmitted the policies expressed in the resolution to the appropriate executive and legislative authorities and made known to the Governor the MSMS policy position. Follow-through is still in process since the reorganization of the state government will continue through 1964.

Resolution 31.—This resolution, referred to The Council for further study, urged MSMS support of a third medical school at Michigan State University by the expansion of the present two-year program.

The County Societies Committee is continuing its study and review of developments.

Substitute Resolution 46.—This resolution directed development of a continuing program of acquiring medical identification items and making them available to physicians at no cost, upon request, for distribution to patients, and also the publicizing of such devices at the Michigan Health Fair.

This matter was referred to the Public Relations Committee. In implementing the recommendations of the House, all MSMS members were sent samples of the medical identification material with a covering letter inviting the physicians to order supplies for distribution to their patients.

The recommendation regarding the Michigan Health Fair will be implemented at the proper time.

Resolution 48.—This resolution directed initiation and maintenance of a program to publicize the harmful effects of cigarette smoking, and to promote an education program, particularly in schools and homes, to keep young people from starting the habit of smoking.

This matter was referred to the Cancer Control Committee which developed a plan for distribution of material on smoking and health for doctors' waiting rooms (through the Michigan Cancer Coordinating Committee). The Committee also cooperated with and supported pilot program of developing teaching manuals for use in Michigan schools. (See Annual Report of the Cancer Control Committee for details.)

The Council also supported a Michigan Department of Health budget request for an educational campaign for youngsters which failed of passage.

Resolution 52.—This resolution instructed Council support of federal legislation to amend the Internal Revenue Code to provide for deductions of premiums of prepaid health insurance by any taxpayer for himself or his legal dependents.

The Council transmitted the sense of the resolution to Congressmen.

Resolution 63.—This resolution urged The Council to consider development of a code of understanding between physicians and pharmacists for eventual submission to the House of Delegates.

The Council's Liaison Committee with the Michigan State Pharmaceutical Association continued its study of a suitable code and is following progress in the development of a national code which might provide some guidelines.

Reference Committee on Medical Care and Prepayment Insurance.—

(a) This report directed The Council to appoint members of MSMS to investigate specific utilization problems referred by Michigan Medical Service or other responsible groups.

The Council appointed an Ad Hoc Committee to Study Procedures of Proposed Utilization Committee, which made detailed recommendations. The Council, upon the advice of Legal Counsel, was compelled to disapprove the Committee's recommendations since implementation of the recommendations requires amendment to the Bylaws. The Council then referred the matter to the House of Delegates Committee on Constitution and Bylaws to be considered by it in conjunction with other studies of revision of MSMS disciplinary and judicial system in cooperation with the American Medical Association.

(b) This report further recommended cooperation with Michigan Medical Service in a program of education for subscribers, management and labor concerning their interest in the proper utilization of prepaid insurance benefits.

The Council referred this matter to the Ad Hoc Committee to Study Procedures for Proposed Utilization Committee. In the several meetings with Blue Shield representatives, the energies of the Committee were directed to developing procedures of the utilization committee as outlined in (a) above.

(c) The report further recommended that the Relative Value Study be restudied and submitted to Michigan Medical Service for monetary interpretation without implementation.

The Council referred this matter to the Relative Value Study Committee which will report its findings in its Annual Report in September.

Reference Committee on Reports of The Council.—This report suggested development of an outline of how to proceed in seeking aid in establishing a medical practice, and means of establishing continuing contact with interns and residents in Michigan.

The Council has assigned these responsibilities to a new Liaison Committee with Interns and Residents.

Reference Committee on Reports of Standing Committees.—

(a) This report recommended that MSMS support enactment of legislation for pooling plans in health insurance.

The Council is pleased to report that such legislation was enacted in 1964 by the Michigan Legislature with support by MSMS and the health insurance industry.

(b) The report further recommended acceptance of the proposed major medical plan for MSMS members, as outlined in the 1963 Annual Report of the Committee on Professional Insurance Plans.

The Council received a specific plan from the Committee, which was re-referred to the Committee to ascertain whether or not the proposed contract was in accord with MSMS policy re professional service benefits.

(c) The report further recommended that The Council review the results of the Kalamazoo and Michigan Hospital Service studies of medical care in physicians' offices, funds to be sought from a foundation if a broader evaluation is necessary.

These instructions were studied by the Medical Socio-Economic Committee, which reviewed the Kalamazoo study, noting that only a small portion of this study involved quality of medical care in physicians' offices. However, because of the value and interest in the entire study, The Council approved a committee recommendation that the summary report of the study be published for distribution to medical leaders in Michigan.

The Committee gave study to the Michigan Hospital Service study and embarked on a survey of additional information in this area in the hope that this would provide valuable information regarding the quality of non-hospital medical care which is of particular interest to the House of Delegates. This study is still in progress. (See Annual Report of Medical Socio-Economic Committee.)

PART IV

Recommendations of The Council

Recommendation One

(See Annual Report of The Council, Part I, Item 11.)

The Council recommends that the President, Chairman of The Council, and the Speaker of the House of Delegates be given a special expense allowance of up to $1,000 each year of their term of office for which they would not be required to account, and that Life Membership in MSMS be automatically conferred upon these officers upon retirement from office.

Recommendation Two

(See Annual Report of The Council, Part I, Item 11.)

The Council recommends that all living Past Presidents, Past Chairmen of The Council, and Past Speakers of the House of Delegates be given Life Membership in MSMS.

Recommendation Three

The Council recommends that upon approval of the two recommendations above the House of Delegates Reference Committee on Constitution and Bylaws be requested to submit appropriate amendments to the MSMS Bylaws for presentation to and action by this, the 1964 House of Delegates.

Recommendation Four

The MSMS Centennial Committee has recommended that MSMS re-charter its component medical societies with appropriate ceremony as part of the celebration of the MSMS 100th Anniversary in September, 1965. This provides an appropriate opportunity for review of the composition of multi-county component societies.

The Council recommends that the House approve the proposal to re-charter component medical societies during the centennial celebration of the Michigan State Medical Society and that the House consider appointment of a study committee to review the composition of multi-county component societies.

Recommendation Five

The question of ethics has been raised before The Council with respect to the use of prescription blanks containing printed advertising of a pharmacy or drug store. Since the

AMA Judicial Council has not promulgated a formal opinion on the subject,

The Council recommends that the AMA Judicial Council be requested to render such formal opinion for the advice of physicians with regard to their ethical relationship with pharmacies.

Recommendation Six

There is a misconception on the part of the public that the word "State" in Michigan State Medical Society denotes a state agency. The Council notes that several state societies have changed their names, removing "State" and substituting "Association" for "Society."

The Council recommends that the House consider adopting a new name for the MSMS at this session of the House of Delegates to take effect at the Centennial Session of the House in September, 1965. Thus, MSMS would embark on its second 100 years as the Michigan Medical Association.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of Part I of the Annual Report of The Council, with commendation to MSMS Legal Counsel Lester P. Dodd for his invaluable advice and service. The Committee also commended the MSMS Journal, "Michigan Medicine," for its new format, scientific material and socio-economic news coverage. The Committee commended the Department of Medical Socio-Economics and encouraged the development and expansion of this Department.

The Reference Committee commended The Council for its detailed informational report on implementation of the 1963 House of Delegates instructions to The Council.

The Reference Committee approved the six recommendations of The Council.

THE HOUSE adopted the report of the Reference Committee.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, reported the following proposed amendments to the Constitution and/or Bylaws, as a result of House approval of Council Recommendations One, Two and Six, the bylaws amendments having been laid over from a previous meeting of the House.

Bylaw amendment based on Council Recommendation One:

Under Chapter 12, Officers, a new Section 10 be inserted, this Section to be entitled "Remuneration," and to read as follows:

"Each of the following officers, namely, the President, the Chairman of The Council, and the Speaker of the House of Delegates shall be entitled to draw from the funds of the Society a special expenses allowance of not to exceed $1,000 in each year of his incumbency of the office. He shall not be required to account to the Society for the expenditure of such funds, which shall be in addition to his ordinary reimbursable expenses."

Bylaw amendment based on Council Recommendation Two:

Chapter 2, Section 6, Life Members. Section A was unchanged. A new Section B was added, Section B providing that, with its adoption, all then living Past Presidents, past Chairmen of The Council and past Speaker of the House of Delegates of this Society shall automatically become Life Members of the Society; and thereafter each President, Chairman of The Council and Speaker of the House of Delegates of this Society shall, upon retiring from office, become a Life Member of this Society, without further action.

This change would be a new Section B of Chapter 2, Section 6. The last few lines of Section 6 would now be designated to read, "A Life Member shall pay no dues or assessments but shall have the right to vote and hold office, and shall be entitled to receive the Journal at such rates as The Council may determine." This is unchanged but is now designated as C.

Proposed Constitutional amendment based on Council Recommendation Six:

That Article 1, Section 1 of the Constitution be amended to read as follows: "NAME: The name of this organization shall be THE MICHIGAN MEDICAL ASSOCIATION."

In addition, if this be adopted, "Michigan State Medical Society" wherever it appears in the Constitution and Bylaws should be replaced with Michigan Medical Association" and the word "Society" wherever it appears with reference to the State organization should be replaced with the word "Association."

THE HOUSE adopted this report of the Reference Committee, automatically laying over until the 1965 Session the proposed amendment to the Constitution.

13. Remarks of Council Chairman—H. H. Hiscock, M.D.

Before I discuss the Annual Report of The Council, I would like to commend the members of The Council for their excellent attendance at the number of meetings to which they are assigned. I would also like to commend our President, Doctor Johnson, and President-elect Oliver McGillicuddy. Their experience has been invaluable. I have called on these men at seven o'clock in the morning and at eleven o'clock at night, and many, many times during their busy office hours, for advice, and it has been given readily.

Next, I would like to commend the staff, under the able direction of our Executive Director, Hugh Brenneman, and the Associate Executive Director, Warren Tryloff. They have made many good changes in the organization of the staff during the short time they have had charge. They took over the first of the year.

We have also made much better use of the building facilities. One change is the new committee library, in which is kept the records of each committee. I am sure you will find this most helpful to the new chairmen of the committees next year.

The annual report of The Council has been distributed to you. Although the report is 21 pages long, this document is a very condensed summary of Council action during the past 12 months.

Minutes of each of The Council's meetings have been sent to interested delegates and component society officers so that you can be informed of problems and actions as they occur. In addition, extracts of Council minutes are published in *Michigan Medicine* following each Council meeting. Our lines of communication have been improved, I believe.

The mimeographed annual report requires no elaboration at this time, but I would like to point out the new format of the mimeographed presentation.

The report is divided into four parts:

Part I is the review of actions of The Council.

Part II lists the annual reports of committees which have been inserted in your Handbook.

Part III reports on implementation of 1963 House of Delegates actions referred to The Council.

Part IV contains The Council's recommendations to the House.

At the meeting of the Reference Committee this afternoon, Dr. Robert Mason, the Council Vice-Chairman, and I will be available to elaborate or answer any questions that may arise.

At this point, however, I would like to report to you certain actions taken by The Council at its meeting yesterday, which are not contained in the mimeographed report.

First, may I call upon C. Allen Payne, M.D., Chairman of the Finance Committee, to review in more detail the report on finance of our Society.

C. Allen Payne, M.D.: Mr. Speaker and Members of the House of Delegates:

It is a pleasure for me to give you a brief review of the finances of our Society. You will be given a copy of the financial report, which includes the status of income, expense and balances of the various MSMS accounts. The report also indicates current assets, investments, fixed assets and liabilities. This report covers the period December 1, 1963 to September 1, 1964, or nine months of our fiscal year.

You will note that all departments are operating economically and substantially in accordance with budgets adopted in January, 1964.

Reserves of almost $100,000 are on hand and consist of

U. S. Government Bonds totaling $57,000 and a liquid savings reserve at the Michigan National Bank of almost $40,000.

The financing of the headquarters building has been reported each year since construction began. As of this date we have outstanding notes at Michigan National Bank totaling $35,000. However, as in the past, it will be necessary to re-borrow during the closing months of the year (October and November) and repay during the early months of 1965 when dues income is high.

This system of financing will permit us to keep a line of credit open until the entire headquarters building debt is retired and, more important, has permitted us to save thousands of dollars in interest during the past four years.

At the end of fiscal 1961 outstanding notes totaled $200,000. By the end of fiscal 1964 we anticipate outstanding notes may total between $90,000 and $100,000.

I believe the financial status of our Society will continue to improve throughout fiscal 1965 provided no projects of major cost are added to our program or other emergencies arise.

Information received from multiple sources during the current year indicate that the Internal Revenue Service by proposed new regulations may bring some of our income into a taxable category. This does not mean that we would lose our tax-exempt status, but we could be subject to taxes on some of our income. The Council already has sought expert advice from a tax consultant in order to be ready when and if the new regulations become effective.

Members of the Finance Committee will be glad to be available for consultation with the Reference Committee or other members of the House of Delegates concerning details of the financial operations of our Society.

In our meetings yesterday we reviewed the detailed statistics and figures which are the usual diet of our Committee, and a single very bright note was introduced. We received a letter from Dr. and Mrs. Orlen Johnson to the effect that they offer a gift of $1,250 to furnish one of the new conference rooms that have resulted from the change in the organization of our headquarters building, and with great commendation the Finance Committee and The Council accepted this gracious offer of Dr. and Mrs. Johnson. [*Applause*]

Thank you, Doctor Payne.

Yesterday, The Council reviewed several annual reports of committees. Two committee reports, which have been distributed to you, have been modified.

The first is the annual report of the ad hoc Committee to Study AMA Concept of Public Health.

The Council reviewed the Committee's report and again reviewed the clarifying statement of the AMA Board of Trustees.

The Council adopted a position statement in lieu of the Committee's annual report, as follows:

> "That the MSMS delegates to the AMA, if in their opinion it is desirable, request the AMA to include in its 1962 AMA Concept of Public Health the interpretive clarifying statement of the AMA Board of Trustees expressed to the 1964 AMA House of Delegates."
>
> The Board of Trustees' statement is as follows:
>
> "It is apparent from a review of the complete reports and the context in which they were considered that the words 'public health' refer to all 'organized community efforts' and not only to health department programs. Activities sponsored by voluntary health associations, medical societies and other health-oriented groups are included under the term. They are expected, together with health departments, to promote community efforts to maintain, protect, and improve the health of the people."

Secondly, The Council amended the annual report of the Relative Value Study Committee to clarify its meaning.

In *Recommendation No. 1,* second line, substitute "the Radiologic Section" for "selected categories."

Recommendation No. 2 is amended to read as follows:

> "Recommended to The Council that health insurance carriers may properly use the various sections of the Michigan RVS by assigning the changed unit values for radiologic procedures."

Recommendation No. 3—No change.

The Council has expressed, and I believe this House will express, its deep appreciation to the physicians who work so diligently on the major problems confronting our committees. These committee reports and studies are the basis for the policy decisions made by the House of Delegates. Our deep appreciation for their efforts and advice.

Lastly, I must express my appreciation for the devoted efforts of the members of The Council. For all of us it is truly a privilege to serve the physician members of MSMS to the full extent of our ability.

Thank you.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of the Remarks of the Council Chairman.

THE HOUSE adopted the report of the Reference Committee.

14. Michigan Health Fair Progress Report—Don W. McLean, M.D.

(Presented to the House by R. K. Whiteley, M.D., in the absence of Doctor McLean.)

This is a progress report from the Arrangements Committee for your Michigan Health Fair. Since this project was adopted at our last Annual Session, the Fair has been detached from our centennial session, and is now scheduled to be held in Cobo Hall from April 30 through May 8, 1966. Thus, it will be the final event in the celebration of the Centennial Year of our Society. Not only is this later date historically more appropriate, but it fits in much better with our school program.

"The primary objectives of the Fair have not changed. It is our intent to present to the public, through exhibits and activities in the broad fields of medical research and health education, authentic information on progress in medicine and allied services. An informed public can better judge the character and quality of health services, and will aid our recruitment of new medical talent and help to expose quackery in its many forms.

"Our primary appeal will be to students from junior high school through college. Dr. Remus Robinson, who is Chairman of our Committee on School Participation, is developing a fine program. The Committee on School Participation is now working with the Wayne County Board of Education, through W. A. McClendon, with the Catholic parochial schools in Detroit through R. A. Owens, with the Detroit Public Schools through Samuel Brownell and his staff, consisting of Carl Byerly, Robert Luby and others. Contact has also been made with the Lutheran parochial schools and other private schools.

"This same pattern of school participation will be followed throughout Michigan. As soon as the nature of the exhibit material becomes available, the Committee will cooperate with the schools in plans for pertinent teaching aids to use in schools throughout the State. Preliminary plans for teaching materials will start about November 8, 1964, or as soon thereafter as the nature of the exhibit materials becomes available. We are planning a comprehensive school evaluation of the material presented to the Fair to enable us to determine the value of the project as a tool for health education.

So far as the general public is concerned, our publicity is under the capable direction of Donald N. Sweeny, Jr., M.D., and his Committee on Publicity. This Health Fair is for all of the people of Michigan, and we will so promote it throughout the State. We believe that appropriate public participation will be assured.

Finances.—As our plans for the Fair developed, it became obvious that our original budget estimate of $100,000 was low. We have now developed what we believe to be a realistic budget of $146,550. Of this sum, the Michigan State Medical Society is providing a fund of $35,000, plus the services of its staff and the facilities of the Society. The remaining $111,550 we plan to raise by subscription from (1) industry, (2) foundations, (3) pharmaceutical houses, (4) banking institutions, and (5) interested paramedical groups.

"Mr. Hugh Brenneman has been appointed public rela-

tions adviser to our Committee, and through him we have retained the services of Mr. Frank Catto for professional direction during our fund-raising drive.

"Our staff has prepared a comprehensive brochure for presentation to prospective donors. As a further aid in solicitation, we have developed a unit scale based upon the gross annual sales of major Michigan industries. One unit of this scale equals $1,200. We plan to ask for contributions of from ½ unit to 12 units or from $600 to approximately $115,000. With this preparation we are now ready to launch this most important activity of raising the money.

"Our Committee on Finance, which is primarly responsible for this job, consists of the following personnel: Robert K. Whiteley, M.D., Chairman; Luther R. Leader, M.D., co-Chairman; Earle A. Irvin, M.D.; William J. Jend, Jr., M.D.; Marion W. Jocz, M.D.; Lyndle R. Martin, M.D.; S. D. Steiner, M.D.; Elmore C. Vonderheide, M.D., and Alfred H. Whittaker, M.D.

"It is apparent that our Finance Committee cannot be expected to do this entire job alone. The responsibility for making contact with prospective donors will have to become the responsibility of the members of this House of Delegates. This is especially true in out-state areas where individual members are best acquainted with the possible sources of support in their area.

"Specifically, we need immediate assistance in the following areas: Grand Rapids, Alpena, Buchanan, Jackson, Muskegon, Bay City, Midland, Dundee, Oak Park, Dearborn, Fremont, Greenville, Warren, St. Joseph, Battle Creek, Romulus, Kalamazoo, Alma, Zeeland, Owosso, Lansing, Port Huron, Tecumseh, Saginaw, Flint and Wyandotte.

"In our survey, we may have overlooked important sources. We urge you to help us with your advice and your active participation in solicitation of financial support and in the general promotion of our Health Fair. Those of you who may already have additional information and ideas, please contact Dr. Whiteley, Dr. Leader, or any member of the Finance Committee. You may do this in the Press Room immediately after this assembly or at any appropriate time during this meeting.

"Remember, the time to act is now. The closing date of this fund drive is November 15, 1964. This is eight weeks from now.

"Continued support of this project by our Society will be contingent upon our success in raising the necessary funds to finance this Fair.

"In view of the current emphasis on physical fitness, we feel that we have an appealing story to tell. Further, we are certain that with the success of our all-Michigan Health Fair we may well establish a pattern for more comprehensive projects of this type in the future, and create an increasing awareness on the part of the public of the value of medical service and the importance of medical research and health education.

"I wish to express appreciation to all of the members who have served on committees for the Fair, and especially to the chairmen of those committees who make up the Committee on Arrangements. They are James D. Fryfogle, M.D.; Luther R. Leader, M.D.; James J. Lightbody, M.D.; Charles P. Polentz, M.D.; Francis P. Rhoades, M.D.; Remus G. Robinson, M.D., and Donald N. Sweeny, Jr., M.D."

THE REFERENCE COMMITTEE on Ways and Means, J. R. Pedden, M.D., Chairman, commended the Health Fair Arrangements Committee for an excellent job and expressed its belief that the Fair is a most worthy educational project which will be a credit to the entire MSMS.

The Reference Committee believed the Health Fair budget to be realistic and felt the necessary funds could be obtained through the proposed program of solicitation.

The Reference Committee recommended to The Council that any reasonable extension of time for the fund drive be considered, if necessary. Further, it was recommended that, if the need arises, there be a voluntary solicitation of the members of MSMS.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE REPORTS

15. Annual Reports of Council Committees

COMMITTEE ON ALCOHOLISM AND DRUG ADDICTION

R. C. Bates, M.D., *Chairman*

Three meetings were held during the year with good attendance The October issue of the MSMS Journal was devoted to alcoholism under the sponsorship of this Committee. Meetings with the Committee on the Study of Prevention of Highway Accidents and representatives of the State Bar Association have led to proposals that might eventually result in legislation aimed at identifying and treating alcoholic drivers.

Through the Michigan Foundation for Medical and Health Education, scholarships were arranged for two Michigan physicians to attend the Rutgers Summer School of Alcohol Studies.

The Committee reviewed several bills in the Michigan Legislature and gave its recommendations to the MSMS Committee on Legal Affairs.

In April the Committee visited Pontiac State Hospital in order to view facilities for treating alcoholics there.

Members of the Committee have participated in several training courses, seminars, and County Society meetings devoted to alcoholism among which the Genesee County Society's "Alcoholism Day" was noteworthy. Increasing numbers of general physicians have shown interest in treating alcoholism this year.

It appears that the Muskegon, Bay City, Battle Creek and Macomb County areas may soon join Flint, Lansing, Brighton and Detroit in opening hospital treatment centers.

Future plans include discussions of drug addicts with representatives of the Michigan State Pharmaceutical Association, discussion of addicted physicians with representatives of the Michigan State Board of Registration in Medicine and participation in television shows on the subject of alcoholism.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON AWARDS

W. A. Hyland, M.D., *Chairman*

Awards were given in the 1963-1964 year according to MSMS tradition.

At the Annual Session held in Grand Rapids in September, 1963, at the direction of the House of Delegates, Certificates of Commendation were presented to Forest D. Dodrill, M.D., Bloomfield Hills; Charles J. Jentgen, M.D.*, Detroit; John M. Sheldon, M.D., Ann Arbor, and Homer H. Stryker, M.D., Kalamazoo.

At the County Secretaries-Public Relations Seminar held in Lansing in February, 1964, the Distinguished Health Service Award was presented to Frederick A. Coller, M.D., Ann Arbor; A. C. Furstenberg, M.D., Ann Arbor; and William J. Stapleton, Jr., M.D., Detroit.

Individual Outstanding Health Service Awards were presented to Mrs. Irene M. Auberlin, of Detroit, President, World Medical Relief; Gordon H. Scott, Ph.D., Wayne State University College of Medicine; Robert Gillespie, R.Ph., President, American Pharmaceutical Association; Alvin M. Bentley, Owosso, Michigan Chairman, Project HOPE; Harry J. Lloynd, Detroit, President, Parke-Davis Company; Senator Frank Beadle, St. Clair, and Representative Edson V. Root, Jr., Bangor.

The following organizations were presented with the Outstanding Health Service Award: Dow Foundation, Midland; Kalamazoo Foundation; Kellogg Foundation, Battle

Creek; Kresge Foundation, Detroit; MacGregor Foundation, Detroit, and Mott Foundation, Flint.

The President's Award was presented to the Presidents of National Organizations following: Reed O. Dingman, M.D., Ann Arbor, American Society of Plastic and Reconstructive Surgery; A. E. Heustis, M.D., Lansing, Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities; R. L. Mainwaring, M.D., Detroit, American Association of Blood Banks; Kenneth P. Mathews, M.D., Ann Arbor, American Academy of Allergists; E. C. Swanson, M.D., Vassar, Federation of State Medical Boards of the United States; Myron E. Wegman, M.D., Ann Arbor, Association of Schools of Public Health, and James LeRoy Wilson, M.D., Ann Arbor, American Pediatric Society.

Also at the Seminar the Outstanding Health Service Award for Communications was presented to the following newspapers: Benton Harbor News-Palladium; Flint Journal; Bay City Times and the St. Joseph Herald Press. The following newspapermen were similarly awarded: Jean Worth, Escanaba; Frank Angelo, Detroit Free Press, and Martin Hayden of the Detroit News. Radio Stations WILS, Lansing; WDET, Detroit; WJR, Detroit; and TV Stations WOOD-TV, Grand Rapids, and WJIM-TV, Lansing, also received the Outstanding Health Service Award for Communications.

The House of Delegates at the Annual Session in September of 1963 recognized the following physicians as having served the science of medicine for fifty years or more: From Genesee County: Leon M. Bogart, M.D., Guy D. Briggs, M.D., Grant Thorburn, M.D., and Elisha W. Caster, M.D.* Alpena County: Charles S. Wilson, M.D. Van Buren County: William Ray Young, M.D. Washtenaw County: Frederick A. Coller, M.D. Macomb County: Milton C. Smith, M.D. Grand Traverse County: Fred G. Swartz, M.D. Kalamazoo County: William Huyser, M.D., and Roy A. Morter, M.D. St. Clair County: D. W. Patterson, M.D. Montcalm County: Isaac S. Lilly, M.D., and O. P. Geib, M.D. Oakland County: Frank B. Gerls, M.D. Ingham County: Maurice L. Richardson, M.D. Houghton County: Raymond E. Hillmer, M.D.

The following doctors from Wayne County were also so recognized: Lowry C. M. Conley, M.D.; Howard Havers, M.D.; Charles S. Kennedy, M.D.; Gordon S. McAlpine, M.D.; William R. McClure, M.D.; Robert C. Moehlig, M.D.; Harold L. Morris, M.D.; William D. Ryan, M.D; Earnest C. Schultz, M.D.; F. Janney Smith, M.D.; Harold F. Ohrt, M.D.; and Clarence L. Candler, M.D.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH CARDIAC DISEASE CONTROL COMMITTEE RE FINANCIAL MATTERS

C. Allen Payne, M.D., *Chairman*

This Committee has not met during the year 1964, and the duties of the Committee are not quite clear. The Chairman did meet with the Cardiac Disease Control Committee and representatives of the Michigan Heart Association, and secured a commitment from the Michigan Heart Association to support the Rheumatic Fever Control program and the centers for one more year, ending November 30, 1964, in the amount of $3,000.00, part of which has already been received by the Cardiac Disease Control Committee.

During this time, the Cardiac Disease Control Committee and the Michigan Heart Association, were to prepare and submit a plan for a new and better Cardiac Disease Control program, which would be reviewed by the Committee, and The Council MSMS, prior to approval. To date, such a plan has not been submitted.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

*Deceased

COMMITTEE ON COORDINATION OF MEDICAL MEETINGS DURING CENTENNIAL YEAR

Orlen J. Johnson, M.D., Bay City

The purpose of this committee was to enlist the cooperation of Michigan groups holding medical meetings during the MSMS Centennial Year and focus these scientific and educational efforts into the MSMS Centennial Annual Session.

In order that MSMS efforts could be directed solely to the production of the Centennial Session, the Michigan Clinical Institute was terminated for 1965.

In addition, the Michigan Academy of General Practice agreed not to hold an annual meeting in 1965, but in lieu thereof to program one day of the MSMS Annual Session, to be known as Michigan Academy of General Practice Day.

It was further agreed that with the discontinuation of the MCI, the Academy will hold its annual meeting in the spring of 1966 and thereafter, thus avoiding conflict with the MSMS Annual Session in the fall.

The Committee believes these arrangements will enhance the Centennial Session and will permit additional growth of future Annual Sessions.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON COURSES ON MEDICAL ECONOMICS AND ETHICS

C. Howard Ross, M.D., *Chairman*

The year has passed, and the Senior Medical Class at the University of Michigan is about to conquer the world. They will blunt the thorns along their path after an exposure to the courses on Medical Ethics and Economics. The year was completed on May 13, 1964.

At Wayne State University College of Medicine, a similar course was performed by certain selectees from the membership, Wayne County Medical Society.

SCHEDULE OF LECTURES BEFORE U OF M SENIOR MEDICAL CLASS

1963

6/19 *Development of a Fee Schedule,* C. Howard Ross, M.D.
Here a relative fee schedule was developed which could be multiplied by 2/3 for Podunk and 4/3 for Minneapolis.

6/26 *A History of Ethics,* C. Howard Ross, M.D.
Performance of the golden rule is followed throughout the centuries.

7/10 *Academic Medicine—Pros and Cons,* Robert E. L. Berry, M.D.
The future Doctors are exposed to the virtues of the ivory tower and the struggles in the market place.

7/17 *Continuing Medical Education,* C. John Tupper, M.D., Associate Dean
The synapses do not die at graduation.

7/31 *An Ethical Approach to Geriatrics,* C. Howard Ross, M.D.
The student romps on a journey from the age 65 to 100.

8/7 *Hospital Day—Akron*

8/14 *Hospital and Internship Day,* W. N. Hubbard, M.D., Dean, and Harry A. Towsley, M.D.
Thirty-nine hospitals in Michigan participated.

8/21 *A Doctor Walks Among Many Religions,* W. G. Fox, M.D.
The great monotheistic religions are reviewed in one morning's round.

8/28 *Granny's Herbs and the Witch Doctor,* C. Howard Ross, M.D.
Lesser medicine breaks through once in 500 times to the upper levels of legitimate therapy.

9/11 *The Ethics and Economics of Hospital Administration,* Henry Morris, Associate Administrator, St. Joseph Mercy Hospital, Ann Arbor.
By elimination of useless jobs and wasteful efforts, insurance rates could be held at the present level.

9/18 *The Surgeon and His Fee,* Charles G. Child, M.D., Chairman, Department of Surgery, Univ. of Michigan Medical School.
What to do with the VIP?

9/25 *A Doctor's Philosophy,* C. Howard Ross, M.D.
Step by step a youth arrives at certain philosophical conclusions before graduation.

10/9 *Duo Practice in the Early Years,* E. C. Pierce, M.D., and M. H. Hiraga, M.D.
A contrast is made between a singleton and duo practice.

10/23 *Sociological Aspects of Ethics,* Wm. Hubbard, M.D., Dean, and George W. Morley, M.D., Department of OB-GYN, University of Michigan.
(a) *Race Explosion.*
(b) *Family Planning.*
(c) *Rhythm Technics Versus Diaphragm and Other Modalities.*
(d) *Therapeutic Abortion, Criminal Abortion.*
(e) *Artificial Insemination.*
(f) *Has the Decrease in the Incidence of Therapeutic Abortion Found Its Origin in Science or Morality?*
(g) *Catholic Hospital Codes, General Hospital Codes.*
(h) *Surgical Attacks on Organs of Procreation Male and Female, Sterilization.*
(i) *Removal of Diseased Organs Containing Embryo.*
(j) *Should a Catholic Resident in a General Hospital Dismiss Himself from an Operation That Specificially Does Not Meet His Code?*
(k) *Doctor and Nurse Relationships in Patient Responsibility.*

10/30 *Orientation Committee, Washtenaw County Medical Society,* Joseph Fisher, M.D., and Winslow G. Fox, M.D.
The students posed as initiates in any county society of the United States.

11/13 *Frank Wilson Memorial Lecture,* Hans Hecht, M.D.

11/20 *The Doctor's Accounting System,* C. Howard Ross, M.D.
We begin with the phone call and end up with schedule C of the federal income tax.

12/11 *The Doctor in Court,* Judge James R. Breakey, Jr.
Here the testifying doctor is top man on the totem pole.

1964

1/8 *Medical Communications and Public Relations,* Mr. Hugh Brenneman and Wallace Teed, M.D.
How the Doctor lives with himself, his patients and the public.

1/15 *Orientation with Specialties,* GP Panel.
(a) *Introduction, Moderator:* C. Howard Ross, M.D.
(b) *General Practice and the Specialties,* Howard Robinson, M.D.
(c) *General Practice in a Metropolitan Area,* Lyle Korum, M.D.
(d) *General Practice with a Rural Setting,* L. O. Shantz, M.D.
(e) *Consultation Techniques,* Clare C. Huggett, M.D.
(f) *Art of the Practice,* F. P. Rhoades, M.D.
(g) *The Family Physician's Place in the Community,* Russell Fenton, M.D.
(h) *General Practice—the Keystone,* A. C. Stander, M.D.
(i) *Medical Organization,* W. L. Rodgers, M.D.

1/22 *Professional Management versus Rugged Individualism,* Douglas Wilson.
Question: Can the rule of thumb still be a success?

1/29 *Medical Practice—A Look Ahead,* C. John Tupper, M.D., Associate Dean
Mother Shipman's prophecy was outdone today.

2/12 *The Doctor and His Home Community,* Stuart Finch, M.D.
A Doctor becomes a neighbor.

2/19 *Medical Manpower,* A. C. Furstenberg, M.D., Dean Emeritus.
Michigan is still a wonderful place in which to practice medicine.

2/26 *The Veterans' Problem,* William Bromme, M.D.
Is service connected disability the only cause for admission?

3/4 *Coordinated Home Care Program,* Sidney Chapin, M.D.
Certain home visits are a proper substitute for convalescent hospital visits.

3/11 *We Joined with the Students, Interns and Residents MCI Detroit.*

3/18 *Medical Placement in Michigan,* Lee Feldkamp, M.D., Robert Price, M.D., and Mr. John Doherty.
How to land in the town of choice.

4/8 *Analysis of Convalescent Homes,* Conducted by: The representatives of Committee on Aging, MSMS, Geriatrics Committee, Washtenaw County Medical Society, Geriatrics Committee, MAGP and local directors of convalescent homes, including Ralph Brandt, M.D., and Lloyd Johnson of Whitehall.

5/13 *Combined Meeting with the Senior Medical Class and the American Medical Writers' Association, Michigan Chapter* (Michigan Union—Ann Arbor).

(a) *Workshop.* I. The Executive Format.
1. *Excellence in Writing,* Harlan Hatcher, Ph.D., President, University of Michigan.
2. *Expansions and Limitations,* Gordon Scott, Ph.D., Vice President, Wayne State University.
3. *Future Dependable Archives,* W. N. Hubbard, M.D., Dean, University of Michigan School of Medicine.
4. *Aiding the Public's Mind in Health Policies,* Myron Wegman, M.D., Dean, University of Michigan SPH.

(b) *Workshop.* II. Editing and Publishing.
1. *The Scientific Editor's Job,* C. J. Tupper, M.D., Editor, JMSMS.
2. *The Managing Editor and Legitimate Advertising,* Herbert Auer, Managing Editor, JMSMS.
3. *Medical Organization's Viewpoint,* Orlen J. Johnson, M.D., President, MSMS.
4. *Finesse in Editorials,* F. P. Rhoades, M.D., Educational Director, AAGP of Michigan.

(c) *Workshop.* III. Mechanization of Materials.
1. *Geriatrics, Medical and Rehabilitational Fields,"* C. Howard Ross, M.D.
2. *Verbal vs. Written Communication,* Charles Sellers, M.D.
3. *Visual Aids,* Sarah Jane Houtz.
4. *Ethics in Writing,* Paul A. Zimmerman, Ph.D., President, Concordia College.

(d) *Luncheon*
1. Address by: W. D. Snively, Jr., M.D., President, AMWA.
(a) *National Meeting AMWA, 1965, Detroit.*
(b) *The Roots of English and Its Application to Medical Writers.*

(e) *Workshop.* IV. The Education Explosion Student Panel.
1. *The Student Looks at Preceptorships,* Richard Erbe, President, Senior Class University of Michigan.
2. *The Student Looks at Internships,* Terry Chamberlain, President, SAMA of U of M.
3. *The Student Looks at Self and Faculty,* R. R. Larsom, President, SAMA, Wayne SU, CM.

(f) *Workshop.* V. General Practice and Specialty Panel.
1. *G.P.'s Place in Medical Literature,* Lyle Korum, M.D., Preesident AAGP of Michigan.

2. *Who Teaches Whom?* E. Clarkson Long, M.D., Executive Secretary, AAGP of Michigan.
3. *Is Our Future Rosy?*, W. S. Smith, M.D., Chief Orthopedics UMMS.
4. *Data vs. Boredom*, Robert Willson, M.D., Chief OB and GYN, UMMS.

(g) *Workshop.* VI. Day's Summary.
1. *For the Present*, Earl F. Wolfman, M.D., Assistant Dean, UMMS.
2. *For the Future*, Alfred H. Whittaker, M.D., President, Wayne County Medical Society.
3. *Critical Review*, Professor James Stokley, School of Journalism, MSU.

(h) *Reception:* Honoring National President AMWA W. D. Snively, Jr., M.D., at home of Dr. and Mrs. C. Howard Ross, 180 Underdown Road, Barton Hills, Ann Arbor.

We are hoping that Lester Dodd's health will permit his entering the program in 1965, with his presentation entitled: "How to Land in Court in 10 Easy Lessons."

Externships have made inroads on total attendance. However, generous students have taken notes and passed the good word along.

We certainly appreciate the excellent contributions and dedication of visiting speakers, committee members and medical students.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICARE

Bradley M. Harris, M.D., *Chairman*

The Committee met in January of 1964 to review the revised contract for patients receiving care under the Medicare Program, operated through the Office of Dependents, Medical Care, Office of the Surgeon-General, U. S. Army.

There being no major changes, the Committee recommended that it be signed by the appropriate MSMS officers.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON NURSING

R. J. Mason, M.D., *Chairman*

This Committee was reactivated in May of 1964 after a period of no meetings for the previous 18 months.

Programming has been directed to re-establishing a closer liaison with the nursing profession and its representatives in matters relating to professional care, educational expansion, inter-relating of patient care and definition of terms.

New harmony has been developed and it is felt that increased activity will result in a better liaison between these two professions.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON ORAL POLIO VACCINE

R. J. Mason, M.D., *Chairman*

This Committee was continued through the year 1964 to be used as a resource or reference committee should difficulties arise relative to the use of live oral polio vaccine in the State of Michigan.

Since no controversies were presented, the Committee held no meetings and we would recommend that the Committee be dissolved.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON REHABILITATION

S. D. Steiner, M.D., *Chairman*

This Committee met twice as follows: November 13, 1963 and March 19, 1964. Our main work consisted of a survey of medical rehabilitation facilities in Michigan for the physically impaired with the goal in mind that such information would be of great value to the medical profession.

After many hours of concentrated study, developing and testing, a recommended survey questionnaire was sent to The Council for approval. A recommendation was also made to The Council that this survey be conducted through MSMS component societies to assure that the information obtained would reflect the best possible medical evaluation of available rehabilitation facilities and services. These items were approved by The Council at its meeting of April 15, 1964.

The presidents of all MSMS component medical societies were contacted on April 27, 1964, and asked to implement this survey through their respective rehabilitation committees or some other appropriate committee.

This survey is still in progress and final results will be made available upon its completion.

We express our deep appreciation to Robert Chandler, Ph.D., of the General Motors Corporation who volunteered valuable consultation services to the Committee regarding the structuring and testing of the survey questionnaire.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

AD HOC COMMITTEE TO STUDY PROPOSED UTILIZATION COMMITTEE

H. H. Hiscock, M.D., *Chairman*

The 1963 House of Delegates adopted the recommendation of the Reference Committee on Medical Service and Prepayment Insurance: "We are particularly interested in the continuing problem of utilization control. We feel that no person other than a qualified physician, and no group or organization other than one composed chiefly of practicing physicians, is competent to form judgments as to the propriety of any medical service. The Reference Committee would therefore recommend the following realistic approach to utilization control:

"The Michigan State Medical Society should accept the obligation for utilization control. We therefore recommend that The Council appoint members of the Michigan State Medical Society to investigate specific utilization problems referred by Michigan Medical Service or other responsible groups. These physicians should be compensated by the MSMS and we further recommend that Michigan Medical Service cooperate in defraying the costs of such investigations."

The Council appointed this Committee to study the overall problem and make recommendations regarding the procedures that should be followed by the utilization committee as recommended by the House.

The Council had preliminary discussion with officers of Blue Shield and this Committee met formally with Blue Shield representatives on two occasions. In addition, information was provided by mail and personal contact.

The Council at its meeting with the MMS Board on March 10 discussed this problem.

At its April 9 meeting, this Committee adopted several

recommendations for the operation of a utilization committee, as follows:

"MOTION: That this Committee recommend to The Council that there be established a Medical Review and Arbitration Committee of the Michigan State Medical Society; carried.

"MOTION: That this Committee recommend that The Council urge and encourage each component society to establish a committee similar to the MSMS Medical Review and Arbitration Committee, these committees to be formed so that any individual, group or insurance company directly concerned may present to the component society any instance where information leads them to believe that medical care rendered deviates from the accepted practice in the area. This information, in writing, shall be made available to the Medical Review and Arbitration Committee of the component society. Such information shall be held confidential by all persons, groups and organizations involved. The Medical Review and Arbitration Committee shall consult any and all of the parties involved and review the information and facts outlined. When the decision has been reached, the findings of the review shall be made available to those concerned. When the physician concerned is considered to have handled a case in a manner judged to be proper medical practice in Michigan, the complainant shall be so notified. If the manner of handling the case in review is not considered proper and adequate medical care, appropriate corrective action shall be taken. Either party may appeal the findings of the Medical Review and Arbitration Committee of the component society to the Medical Review and Arbitration Committee of the Michigan State Medical Society; carried.

"MOTION: That the Medical Review and Arbitration Committee of MSMS, acting as an appeal body, is responsible for the establishment of proper procedures for appeal. It shall have the power to make recommendations to component societies regarding the handling of disciplinary matters in order that such matters, if appealed, are in satisfactory condition so that a fair and just decision may be reached by the MSMS Medical Review and Arbitration Committee. The MSMS Medical Review and Arbitration Committee has the authority to recommend solutions that may be prescribed by component society committees or the MSMS committee in the event the alleged violation was found to be true as charged; carried.

"MOTION: That the above recommendations be referred to MSMS Legal Counsel for opinion prior to submission to The Council; carried."

The Council approved the intent of the recommendations subject to the advice of Legal Counsel.

Subsequently, The Council disapproved the Committee's recommendations, on advice of Legal Counsel, inasmuch as implementation of the recommendations requires amendment of the Bylaws. Council recommended that this matter be referred to the House of Delegates Standing Committee on Constitution and Bylaws to be considered by it in conjunction with other studies of revision of the MSMS disciplinary and judicial system in cooperation with the AMA.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON VETERANS' AFFAIRS

William Bromme, M.D., *Chairman*

All members of the Committee were circularized during the past year regarding potential agenda items but the consensus was that there was no business which warranted the calling of a meeting. As you know, the major present responsibility of this Committee is the negotiation of new fee schedules with the Veterans' Administration in regard to the Home Town Care Program. It is believed that there is no reason for entertaining this problem at this time since relationships with the Veterans' Administration regional office are extremely good.

The Chairman reports with regret the untimely death of Doctor William A. Scott, who had been a faithful member of this Committee for years.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH MICHIGAN STATE BOARD OF REGISTRATION IN MEDICINE

K. H. Johnson, M.D., *Chairman*

The Council, MSMS, referred to this Committee Resolution No. 3 of the 1963 MSMS House of Delegates and directed the Committee "to investigate the problem implied therein and to proceed to recommend means of implementing solutions to the same under the philosophy of the resolution." In order to accomplish this charge, the Committee consulted with MSMS Legal Counsel.

After study, Legal Counsel rendered his opinion that the creation of a State Medical Disciplinary Board with composition called for in Resolution No. 3 would probably not stand the test of constitutional validity under the Michigan Constitution.

Resolution No. 3, as passed by the 1963 House of Delegates, was worded in such a manner as to preclude its implementation through the legislative process. Creation of a State Medical Disciplinary Board by the Michigan Legislature as an official agency of state government could not be done in such a manner as to require that the Board members be selected by an unofficial body such as the MSMS House of Delegates. If, therefore, the concept of a State Medical Disciplinary Board is to be pursued, a revised resolution should be adopted by the House of Delegates.

The Committee noted, however, that MSMS successfully urged the Michigan Legislature, during the 1964 session, to increase the budget for the State Board of Registration in Medicine to an extent which would offer greater opportunity for investigation and discipline in those instances where actual illegal acts have been committed. The Committee further is aware of the fact that attention is being given at a national level to the drafting of a recommended model Medical Practice Act which will undoubtedly suggest ways and means for handling disciplinary and similar problems, and that MSMS is reviewing its own judicial and disciplinary procedures.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION MEDICAL EDUCATION LOAN GUARANTEE PROGRAM

Progress Report through December 31, 1963

O. B. McGillicuddy, M.D., *Michigan Chairman*

Borrowing Increases in Second Year

By the end of 1963, a total of 11,876 bank loans with a principal value of nearly $14 million had been guaranteed under the AMA-ERF Loan Program. There were 8,430 medical students, interns and residents who had borrowed, 3,739 of them for the first time in 1963.

The rate of borrowing in 1963 increased slightly from 1962. In 1963, an average of 546 loans were made each month, compared with 532 the previous year.

Represented in the program are students at 85 medical schools and interns and residents in 583 hospitals in 47 states and possessions.

Repayments Begin

Eventually, as more and more borrowers pay back their loans, the amount of repayments will offset new loans being made. At that point, estimated to be about seven or eight

years away, additional contributions to the Guarantee Fund will not be needed.

Until that time, new money must be added to the Guarantee Fund. Provided the borrowing rate does not rise, however, the amount needed should decrease annually because of the growing amount of loans being repaid. A total of 319 borrowers had returned money to the program by the end of 1963. Of these, 58 paid off their loans in full, and the others began monthly repayment plans. In addition, AMA-ERF purchased five loans from the Continental Illinois National Bank. Four of these notes were in default through death.

At the present borrowing rate, approximately $750,000 will be required to guarantee loans in 1964.

Support of Guarantee Fund Grows

Contribution support of the Loan Program continued strong in 1963.

Once again, physicians, as individuals and through their medical societies and professional organizations, gave approximately half of the funds contributed during the year, matching gifts from industry and related sources.

By year's end, 66 companies and company foundations and 41 medical organizations had contributed. Of these, 25 gave in both years, 64 gave for the first time in 1963 and 18 gave only in 1962.

With each dollar in the Guarantee Fund covering $12.50 in loan principal and accrueable interest, approximately 75% of the fund had been committed at the end of 1963.

Government Program Authorized

During 1963, Congress passed legislation calling for government loans to students of medicine, dentistry and osteopathy. Scheduled to begin in 1964, the three-year program calls for appropriations of $5.1 million the first year, $10.2 million the second year and $15.4 million the third year.

The government program stipulates no interest shall accrue on loans while the student is in school, nor for three years following graduation. At that point, the loan is repaid with 3% simple interest, or the prevailing government rate, charged on the unpaid balance.

The AMA-ERF program is based solely on individual responsibility and involves no subsidy. It provides for a 5.5% simple interest rate accruing annually during the training period, and 6.5% simple computed on the monthly unpaid balance during repayment.

Impact on AMA-ERF Program

It cannot be determined at this time what effect the federal program will have. Three factors, however, may be influential.

1. Government loans, because they are interest-free, could increase the overall demand for loan funds among medical students, rather than displace existing demand.

2. Actually, the government program intends to concentrate on freshmen the first year, freshmen and sophomores the second year and freshmen, sophomores and juniors the third. Initially, this policy should have little impact on the AMA-ERF program. Of AMA-ERF loans made in 1963, only 7% went to freshmen, 16% to sophomores and 19% to juniors—nearly 60% went to seniors, interns and residents.

3. AMA-ERF, of course, intends to maintain its Loan Program as a ready and convenient resource for any medical student, intern or resident who meets the minimal qualifications. It hopes to demonstrate, through continued experience, that private voluntary contributors and organized medicine are increasingly capable of meeting the borrowing needs of medical trainees in tradition of self-help.

Loans in Michigan (State of Training)

1962 Loans	*1963 Loans*	*Total*	*Total Principal*
153	197	350	$411,300

Loans at Michigan Medical Schools

School	*1962 Loans* (10 mos.)	*1963 Loans* (12 mos.)	*Total* (22 mos.)	*Total Principal* (22 mos.)
Michigan	49	30	79	$ 86,000
Wayne	40	48	88	101,600

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICINE AND RELIGION

RICHARD L. RAPPORT, M.D., *Chairman*

On December 18, 1963, the MSMS Committee on Medicine and Religion held its organizational meeting. Representatives from the Department of Medicine and Religion of the American Medical Association were present to inform us of experiences in other states.

The purpose of the Committee was clearly defined as follows: To encourage component medical societies to organize local committees and implement programs to increase understanding between the clergy and the physician in the interest of better patient care. Initial efforts were limited to county medical societies represented by members of the State Committee.

A second meeting was held May 13, 1964, and excellent progress reports were submitted by the following counties: Kent, Ingham, Genesee, Monroe, Saginaw, and Washtenaw.

The Chairman has written an editorial for the State Journal outlining the purposes of the Committee.

A multitude of activities have been planned for the fall of 1964.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH RESIDENTS AND INTERNS

N. D. HENDERSON, M.D., *Chairman*

In previous years, liaison and contact between MSMS and interns and residents has been maintained principally through the Annual Conference for Residents, Interns, and Senior Medical Students. This one-day meeting took place during the Michigan Clinical Institute.

Three factors led to the creation of this new Liaison Committee with Residents and Interns:

One, no future MCI's are planned, thus the annual Conference cannot be tied into that postgraduate meeting.

Two, the 1962-63 Committee to Study Establishment of Loan Fund for New Physicians recommended creation of a special committee to improve liaison and communications with new physicians.

Three, the Planning Committee for the Interns-Residents Conference had made certain recommendations which warranted study.

The Committee is studying the recommendations of these several committees, the House of Delegates and The Council, and will schedule an early fall meeting to develop specific liaison plans for 1964-65.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RETIREMENT PLAN

R. K. WHITELEY, M.D., *Chairman*

Based upon a review of the Michigan Professional Service Corporation Act of 1962, and the Federal Self-Employed Individuals Act of 1962 (Keogh Law), the Committee completed its study of a proposed retirement plan for the members of the Michigan State Medical Society.

This plan, based upon the Keogh Law, was developed with the help of McCoy, McLaurin and Lackey, Inc., and has been submitted to The Council for its information and recommendation.

Before making a determination, The Council has requested

that McCoy, McLaurin and Lackey, Inc., provide more detailed information.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE BAR OF MICHIGAN

W. M. LeFevre, M.D., *Chairman*

Your Committee held no meetings during the year. The business of a cooperating code including the Michigan Hospital Association had been completed previous to the 1963 Annual Meeting.

It is the thought of the Committee, however, that the Committee should be continued in order to be ready to deal with any pertinent matter which might arise.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH STATE EXECUTIVE OFFICE

K. H. Johnson, M.D., *Chairman*

The purpose of the Liaison Committee is to supply advice and counsel to the Governor and his staff with respect to medical matters or matters of interest to the Michigan State Medical Society, and to make its services available in relation to any program aimed at improving the health of the people of Michigan.

In discharging these responsibilities the Committee, during the past year, has met as required with the Chief Executive of Michigan, and has kept appraised of the viewpoint of the Governor's office with respect to all legislation of interest to the medical profession. A large number of recommendations for appointment to various health boards, committees, councils and commissions in state government were made through the Committee and subsequently favorably acted upon by the Chief Executive. The Committee has also, upon request, recommended through The Council and to the Governor, MSMS representatives to various conferences dealing with health matters. It also participated in the successful effort to gain Executive Office support for the repeal of Rule 10 in the MAA program.

Finally, the Committee continues to maintain close liaison with the Executive Office with respect to the impending reorganization of the executive branch of state government, particularly as this will affect the health and licensing agencies.

Each action of the Committee has ben reported in detail to The Council.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

AD HOC COMMITTEE TO STUDY ESTABLISHMENT OF MSMS SERVICE CORPORATION

O. B. McGillicuddy, M.D., *Chairman*

The matter of the advisability of MSMS establishing a separate corporation for the purpose of providing special services for MSMS members is still under active study by this committee.

The establishment of such a service corporation might be desirable if MSMS tax status is felt to be in jeopardy as a result of recent Internal Revenue rulings regarding unrelated income of business leagues.

The Council has authorized a complete review of the MSMS tax position. Following this, the committee will be in a position to make a determination and recommendation.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

LIAISON COMMITTEE WITH THE MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

R. V. Daugharty, M.D., *Chairman*

The Liaison Committee considered and acted upon a number of matters vital to both professions during 1963-1964, including the question of physician ownership of pharmacies, corporate ownership of pharmacies, legislation before the 1964 state legislature dealing with drugs, pharmaceutical services in hospitals, and the development of a code of understanding between physicians and pharmacists.

In connection with physician ownership of pharmacies, the committee recommended a policy, adopted by The Council of MSMS, that "It is fundamental that all individuals, whether receiving professional services by private or public means, have freedom to select the pharmacist from whom they receive such services." A congressional investigation into this area is currently being undertaken and the committee continues its intensive examination into the activities of the U. S. Senate Committee as they relate to Michigan.

The committee has continued to review Michigan developments relating to the question of corporate ownership of pharmacies. It has also concerned itself with providing technical data relating to state legislation adding paregoric to the roster of drugs requiring a prescription, and has studied the suggested principles and guidelines for pharmaceutical services in hospitals which were developed subsequent to the adoption of a revised pharmacy code in Michigan.

The committee, recognizing that the American Medical Association and the American Pharmaceutical Association have given consideration to the development of a "Code of Understanding" between the two groups at a national level, has refrained from making a specific recommendation with respect to adoption of a locally-developed Code pending an analysis of a document which may emanate from the national organizations and, with minor modifications, be most desirable for state use.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON UNIFORM FEE SCHEDULE FOR GOVERNMENTAL WELFARE AGENCIES

W. M. LeFevre, M.D., *Chairman*

As directed by The Council, this Committee completed the assignment of developing a new Uniform Fee Schedule for Governmental Welfare Agencies, which is based on the policy "that wards of government be not treated as indigents, and that physicians be compensated by the usual fair fee for their services."

This Committee has recommended to The Council that the Michigan Relative Value Study of 1961 be adopted as the new "Michigan Uniform Fee Schedule for Governmental Welfare Agencies" with a monetary value of $3.50 to be applied to the unit values listed, both X and Y, in all sections.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO STUDY WORKMEN'S COMPENSATION

Wm. Jend, Jr., M.D., *Chairman*

This Committee was created by The Council, MSMS, upon recommendation of the MSMS Occupational Health Committee that a special group be appointed to work toward strengthening and improving the medical aspects of the administration of Workmen's Compensation.

The Committee has kept fully abreast of developments in regard to its assignment. The work of a 1963-1964 Executive Department study committee was reviewed and recommendations were made to the study committee. A Workmen's Compensation legislative proposal in the 1964 session was reviewed and recommendations made thereon through the MSMS Legal Affairs Committee to The Council. This legislative proposal did not become law.

The Committee is currently cooperating with the State Legislative Interim Study Committee which is working on a proposal for the 1965 State Legislature. Due to the complexity of this subject and the continuing nature of the assignment, this Committee has requested that it be authorized to continue its work during the coming year.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

JOINT COUNCIL TO IMPROVE HEALTH CARE OF THE AGED

A. Hazen Price, M.D., *Chairman*

The Joint Council to Improve the Health Care of the Aged held no meetings during the past year. This Committee was comprised of representatives of the Medical Profession, Michigan Nursing Home Association, Michigan Hospital Association and the Michigan State Dental Society.

Representatives of the Michigan Nursing Home Association attended one of the meetings of the Committee on Aging, and no matters were presented which required a meeting of this group.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

PERMANENT CONFERENCE COMMITTEE WITH MICHIGAN HOSPITAL ASSOCIATION, MICHIGAN LEAGUE FOR NURSING, MICHIGAN STATE NURSES ASSOCIATION

Raphael Altman, M.D., *Chairman*

This Committee did not meet during the past year. A new Committee on Nursing has held two meetings with representatives of the Michigan State Nurses Association and reviewed the problems that formerly would have been discussed with this group.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

DISASTER MEDICAL CARE COMMITTEE

G. L. Otis, M.D., *Chairman*

The Disaster Medical Care Committee held three meetings during the past year, February 15, May 20 and July 22.

The Committee has continued its cooperation with the Michigan Department of Health, the Michigan State Police, and its liaison with the many other organizations in Michigan that would be involved in patient care and in public health, in the event of a disaster. Efforts are continuing to develop a county and regional organization, especially in cooperation with the Michigan Hospital Association, existing hospitals and the Civil Defense Emergency Hospitals stored throughout the state. Recent contacts with the Michigan Hospital Association point to improved liaison for the coming year and the expectation of moving out of the planning stages into the training stage for disaster medical care.

The Committee appreciates the cooperation of the members of the Michigan State Medical Society in the past and hopes for increased activity at the local level during the coming year.

THE REFERENCE COMMITTEE on Reports of The Council, Alexander W. Blain, III, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

MICHIGAN CRIPPLED CHILDREN COMMISSION

A. C. Stander, M.D., *Chairman*

This Committee had its first meeting on June 4, 1964.

Payment for the care of afflicted children under one year with diarrhea was discussed, and R. G. Rice, M.D., stated that these cases could be taken care of by the MCCC.

The resolutions and substitute resolution of the 1963 House of Delegates were discussed.

A discussion of burn cases revealed that after approximately 30 days care these cases were considered a crippled children's case, and reconstructive surgery would have to be done by Certified Plastic Surgeons. Also, qualifications of men doing Crippled Children's work would be under the guidance of the Commission's Medical Advisory Committee.

Elective surgery cases, principally tonsilectomies and adenoidectomies, under the Afflicted Children Program would require a second opinion, but could be performed by any surgeon considered qualified by the staff of an approved hospital.

The Commission assured the members of the Committee that they are engaged in a continuous process of seeking to simplify billing methods. On the question of "field clinics," the Commission stated this matter is undergoing constant evaluation.

Recent legislation that raised the fee schedule to 80% of Michigan Uniform Fee Schedule for Governmental Welfare Agencies was referred to, and the expectation that this may be raised to 100% in 1965 legislation was voiced by Commission members.

The Committee moved that "The Council recommend to the House of Delegates of the Michigan State Medical Society be requested to adopt the position that in any governmental reorganization, the identity of the Michigan Crippled Children Commission be retained intact as a functioning unit."

The entire Commission and its Medical Director were present, and Chairman Martin Fleming expressed for the Commission that body's unanimous opinion that liaison meetings are most welcome and a continuation of the present activity will be mutually helpful.

THE REFERENCE COMMITTEE on Reports of The Council noted that The Council did not accept the Liaison Committee's recommendation regarding taking a position on the MCCC's future relationship in the plan for reorganization of state government. With this exception, the Reference Committee recommended approval of this annual report.

THE HOUSE adopted the report of the Reference Committee.

AD HOC COMMITTEE TO STUDY AMA CONCEPT OF PUBLIC HEALTH

R. J. Mason, M.D., *Chairman*

The Council adopted a position statement in lieu of the Committee's annual report, as follows:

"That the MSMS delegates to the AMA, if in their opinion it is desirable, request the AMA to include in its 1962 AMA Concept of Public Health the interpretive clari-

fying statement of the AMA Board of Trustees expressed to the 1964 AMA House of Delegates."

The Board of Trustees' statement is as follows:

"It is apparent from a review of the complete reports and the context in which they were considered that the words 'public health' refer to all 'organized community efforts' and not only to health department programs. Activities sponsored by voluntary health associations, medical societies and other health-oriented groups are included under the term. They are expected, together with health departments, to promote community efforts to maintain, protect and improve the health of the people."

THE REFERENCE COMMITTEE on Reports of The Council recommended approval of The Council's position statement. However, the Reference Committee felt MSMS should go farther in defining the proper role of public health departments and recommended that such a precise definition be developed.

THE HOUSE adopted the report of the Reference Committee.

HOSPITAL RELATIONS COMMITTEE

E. E. Martmer, M.D., *Chairman*

This Council committee is responsible for combining medical and hospital interests so as to improve health care and to maintain minimum hospital cost through such cooperative effort. It is charged with concerning itself with rules and minimum standards for hospitals, principles of hospital-physician relationships and hospital-physician responsibilities. The Committee regularly meets with a liaison group representing the Michigan Hospital Association and its deliberations are reported to The Council, MSMS and the Board of Trustees, MHA.

Two meetings of the Committee were held, one in February and one in March, devoted to consideration of a proposal, incorporated in a resolution adopted by the Board of Trustees of the Michigan Hospital Association on January 8, 1964, that certain Blue Shield Class II Benefits (anesthesiology, pathology, radiology, and internal medicine as it relates to cardiology) should be transferred to Blue Cross contracts. At the first of these meetings presidents of the four affected specialty groups were present and expressed unanimous oppostion to such transfer.

Michigan Hospital Association representatives, at the second meeting, agreed to recommend withdrawal of the resolution contingent upon support of the Michigan State Medical Society for a strong and continuing liaison between the Michigan Medical Service and the Michigan Hospital Association. MSMS support was given as requested. Subsequent to this the Board of Trustees of the Michigan Hospital Service was given a staff recommendation that anesthesia services, if "hospital provided," be made a contract benefit.

The Council was requested by the Hospital Relations Committee to strengthen and broaden a channel of liaison between MSMS and the Michigan Hospital Service and, upon notification of the development involving anesthesia services, The Council established a Liaison Committee with Michigan Hospital Service (with membership substantially the same as the Hospital Relations Committee, pending discussion with Michigan Hospital Service).

A third meeting was then held and attended by guests representing MHS Medical Advisory Committee, the Michigan Medical Service and the Michigan Society of Anesthesiologists, and reported to The Council as a report of the "Liaison Committee with Michigan Hospital Service." This third meeting was held on June 28, 1964.

MHS had requested a meeting with the Michigan State Medical Society on July 2, 1964, and the meeting was held at the Michigan Hospital Service building in Detroit with Mr. W. S. McNary, MHS President, presiding. Representatives of Michigan Medical Service, Michigan Hospital Service, Michigan State Medical Society, and Michigan Society of Anesthesiologists were present and each stated their views on the question of payment for anesthesiology services.

At the June 28 meeting, the following statement was developed to serve as a guideline for the MSMS representatives in the discussion with MHS, and it was expressed by Orlen J. Johnson, M.D., President of MSMS, on July 2:

"We believe that all subscribers to Michigan Medical Service and Michigan Hospital Service contracts should have available adequate anesthesia service at all times. We also believe that there should be no dual payment for a single service, and that:

(1) Payment for professional services of physicians (other than those training) is a responsibility of Michigan Medical Service (this being consistent with the policy of both the American Medical Association and the Michigan State Medical Society):
(2) The administration of anesthesia by a registered nurse in the employ of a hospital is a hospital service, for which Michigan Hospital Service should provide the hospital compensation under the reimbursable formula.

It is recommended that, in the implementation of the above recommendations, Michigan Medical Service, and Michigan Hospital Service give due consideration to the solution of individual problems which may result from the clarification of their individual responsibilities."

The July 2 meeting was adjourned without any action being taken.

Prior to the July 16-18 Council meeting, the foregoing statement was transmitted to all Council members; the statement was adopted by The Council, and delivered to both Michigan Hospital Service and Michigan Medical Service on July 17, 1964.

Although most of its activity during 1963-1964 was related to the foregoing, it should be noted that the Hospital Relations Committee served as a vehicle for mutual understanding and cooperation between the Michigan State Medical Society and the Michigan Hospital Association in matters involving legislation during the 1964 legislative session.

THE REFERENCE COMMITTEE on Reports of The Council wholeheartedly supported the actions of this Council Committee in its efforts to see that professional service remains the responsibility of Michigan Medical Service.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RELATIVE VALUE STUDY

L. R. Leader, M.D., *Chairman*

The Committee held meetings on January 12, 1964, April 12, 1964, June 7, 1964, July 1, 1964, and July 26, 1964.

As instructed by the 1963 House of Delegates, the Committee's chief work was to study the matter of alleged inequities in the Michigan Relative Value Study (see Resolution below).

As a result of this study, the Committee has taken the following action:

1. Submitted to The Council for approval, suggested changes in the Radiologic Section of the Michigan RVS.
2. Recommended to The Council that health insurance carriers may properly use the various sections of the Michigan RVS by assigning the changed unit values for radiologic procedures.
3. Recommended to The Council that an RVS Committee should continue to function so as to continue the task assigned by the 1963 House of Delegates.

1963 Amended Substitute Resolution Adopted in Lieu of Resolutions Nos. 12, 19, 20, 21, 22, 23, 32, 33, 45, 47, 55, 60, 61, 67, 69, 70

MICHIGAN RELATIVE VALUE SCALE

Whereas, the 1962 House of Delegates of the Michigan State Medical Society requested Michigan Medical Service to implement the Michigan Relative Value Scale at such time as it considered practical, and

Whereas, the Board of Directors of Michigan Medical Service has completed and forwarded its study including computer data to the 1963 House of Delegates for the information of its members, and

Whereas, it has been alleged that there are inequities present which require further study of economic considerations

and discussion with all segments of the medical profession of Michigan, therefore be it

RESOLVED: That the Relative Value Scale be not implemented at this time by the Michigan Medical Service; and be it further

RESOLVED: That the problem of these alleged inequities be recommitted to the presently constituted Relative Value Study Committee; and be it further

RESOLVED: That any revised Scale developed by the Relative Value Study Committee be submitted to Michigan Medical Service for monetary interpretation only, without implementation, and then return to the House of Delegates at a special or the next regular meeting, whichever is practicable.

THE REFERENCE COMMITTEE on Reports of The Council recommended approval of this annual report as amended by The Council, emphasizing support of the RVS Committees' recommendation continuing the function of the Committee.

THE HOUSE amended the report of the Reference Committee by changing Recommendation 2 to read as follows:

2. Recommended to The Council that health insurance carriers may properly use the various sections of the Michigan RVS and assign unit values to medicine, surgery, pathology and roentgenology.

THE HOUSE adopted the report of the Reference Committee as amended.

16. Annual Reports of Standing Committees

COMMITTEE ON CANCER CONTROL

H. J. VandenBerg, Jr., M.D., *Chairman*

The Cancer Control Committee met on three occasions, November 1963, February 1964 and May 1964. Its actions and recommendations were as follows:

1. *Cancer Registry Bill.*—The Committee approved the principles involved in the proposed legislation in a bill to be submitted to the Michigan Legislature concerning a Cancer Registry Bill submitted by the Michigan Cancer Registry. The bill was essentially the same as that submitted to the 1963 Legislature, which was not acted upon. The purpose of the bill was to establish recognition of a Cancer Registry as a "Medical Research" project by its denotation by the State Health Commissioner as a "Medical Research" project without his bona fide participation in the project.

2. *Education Campaign on Hazards of Smoking.*—The Council referred Resolution No. 48 of the 1963 House of Delegates to this Committee for implementation. The Committee requested The Council to remind all Michigan physicians of the hazards of cigarette smoking. Further, physicians were requested to perform a health education service to their patients by (1) encouraging patients not to begin the practice and (2) encouraging smokers to stop or curtail their smoking.

Guidance and support was given the pilot program of smoking education in Michigan schools. This program developed, tested, and finalized curriculum guides for teaching students facts on smoking and health. The Cancer Control Committee was provided a detailed progress report of the pilot program in January by Robert Luby, Ph.D., Director of Health Education of the Detroit school system. With the finalization of the curriculum guides, many voluntary health organizations have joined a State Coordinating Committee on Smoking. Your Chairman of the MSMS Cancer Control Committee has accepted an invitation to head this group. The State Coordinating Committee will distribute the curriculum guides to all schools in Michigan with the Michigan Health Council serving as the coordinating agency during the 1964-1965 school year.

3. *Distribution of Literature on Smoking to MSMS Physicians and Members of the Michigan State Dental Association.*—The Committee selected five pamphlets relating to smoking and health from a considerable volume of such literature for distribution in doctors' and dentists' waiting rooms. It recommended that the distribution and cost of this literature be borne by the Michigan Cancer Coordinating Committee. The MCCC, of which MSMS is a member organization, agreed to underwrite the cost of the distribution up to $3,000.

The initial response to the mailing was double that expected and nearly 340,000 pamphlets have been mailed to requesting physicians and dentists for distribution to patients.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of the Annual Report, pointing out to the House that the Cancer Registry Bill mentioned in paragraph one was not passed by the Legislature in this form. (See report of Legal Affairs Committee.)

THE HOUSE adopted the report of the Reference Committee.

CARDIAC DISEASE CONTROL COMMITTEE

S. E. Chapin, M.D., *Chairman*

At its only meeting of the past year, on May 13, 1964, the Committee on Cardiac Disease Control discussed the "Purposes" of the Committee and advises that they be changed to read as follows:

"The Committee shall establish communication with all organizations and agencies who develop information on heart disease for the enlightenment of the medical profession and public. It shall assist in the distribution of these materials, and it shall advise these organizations and agencies on timely approaches to various aspects of heart disease control."

In other actions, the Committee reviewed the six-point program of the Michigan Heart Association in relation to rheumatic fever control, approving the encouragement of the use of "rapid fluorescent antibody detection of Streptococcus," the establishment of a statewide rheumatic fever registry to assist bicillin distribution, and the support of the Michigan Crippled Children Commission's diagnostic clinics. The Committee encouraged the MHA to hire a physician to administer a statewide program in rheumatic fever control.

Arrangements for the printing and distribution of an updated set of rheumatic fever cards to members of the Society were completed. This will start on November 1. Similiar desk reference cards on stroke diagnosis, treatment and rehabilitation will be handled in a similar manner.

The limited distribution of the locations of de-fibrillators to interested parties was approved. This project is being undertaken by the Michigan Hospital Association.

A survey of Michigan's county medical societies on two matters was completed with the following results:

1. There are few areas where rheumatic fever clinics are needed or desired.
2. Most societies did not feel that the inclusion of congenital heart disease diagnosis in a clinic of this type was desirable.
3. Many societies requested speakers and programs on specific aspects of heart disease, and these were all filled.
4. Twelve county societies have conformed with 1963 MSMS House of Delegates Resolution, re: "Instruction in External Cardiac Massage" by implementing such programs; 8 other societies have formed committees; 11 societies have future plans.
5. It was learned, via the survey, that wide implementation of the method of resuscitation has been accomplished in many areas by various hospitals, the MHA program and county society committees.

The Committee further suggested that the MSMS Committee on Postgraduate Medical Education develop panel discussions on:

1. Stroke rehabilitation.
2. Preventive aspects of coronary artery disease.
3. Hypertension.

In the future, the Committee contemplates further communication and liaison with other agencies and organizations interested in cardiac disease control.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of the annual report with the following minor changes in wording for clarification:

In the third paragraph, the Reference Committee substituted "Michigan Heart Association" for the letters MHA, to avoid confusion.

Paragraph five, re de-fibrillators, was replaced by a substitute paragraph: "The Michigan Heart Association should prepare and distribute a list of the locations of available defibrillators to all interested parties."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON CHILD WELFARE

R. H. Trimby, M.D., *Chairman*

The Committee on Child Welfare met on April 1, 1964.

1. *Liaison with Michigan Crippled Children Commission.*—R. G. Rice, M.D., Lansing, Medical Director of the Michigan Crippled Children Commission, was introduced and reported briefly on the activities and programs of the Michigan Crippled Children Commission.

Doctor Rice believes the Michigan Crippled Children Commission has the broadest scope of service of any crippled children agency across the country. The removal of tonsils, the cleft-palate program, legislative activity regarding rates to physicians and hospitals, the fate of MCCC under the new reorganization of State government, the aim of the MCCC to get more and more children over on their crippled children program, and the antagonism created when parents are not informed that doctors are not fully paid for the service rendered, were discussed. It was suggested to Doctor Rice that a letter be sent from the MCCC to all parents informing them of the doctor's contribution.

2. *Vaccine Study.*—Dean Myron E. Wegman, M.D., University of Michigan School of Public Health, reports that a new program of investigation is under way to determine the over-all percentage of immunization protection in Michigan.

3. *Training Course for Camp Health Directors.*—A training course, similar to the pattern established in 1963, will be conducted in the summer of 1964.

4. *Conferences on School Health Problems.*—The need for such conferences, and the difficulties involved in holding these meetings, was thoroughly reviewed by the Committee. John M. Dorsey, Jr., M.D., a member of the Committee, said he would be willing to try in his county (Oakland) a pilot program to attempt to gain better communication with local people on school health problems. After a trial period, Doctor Dorsey will report back to the Committee on the effectiveness of his campaign.

5. *Guthrie Test.*—The Committee went on record recommending that the Guthrie Test be done routinely in all hospitals in Michigan.

6. *Tetracycline.*—The Committee recommended that physicians be made aware of the fact, that during the formative period of growth of teeth (birth to age eight), extreme caution should be taken in the use of Tetracycline because both the deciduous and permanent teeth can develop a yellow stain which is permanent.

7. *Subcommittee on School Health Problems.*—This Committee reviewed the matter of high school wrestling and weight control and postponed definite recommendations until a meeting could be held with the Michigan High School Athletic Association's Executive Board.

Other matters to be taken under consideration by this Committee are: (a) the adequacy of Michigan activity in prevention of blindness programs in schools; (b) the preschool hearing and vision testing; (c) the extent of testing in children between the ages of 10 to 14 years; and (d) the all-too-general feeling that removal of tonsils solves all hearing problems.

8. *Subcommittee on Ophthalmology.*—The Committee held two meetings, on August 21, 1963 and on June 10, 1964.

The program of vision screening of children of junior high school age, the pre-school vision-hearing program, the color screening program, and plans for expansion of screening programs in all schools were reviewed with representatives of the Michigan Department of Health. The Committee is happy to report that the School Screening Program in Michigan is growing, more children are being cared for, more people are being acquainted with the program, some 200 technicians who have been trained by Michigan Department of Health vision consultants are testing the vision of preschool and school age children under the supervision of the Department's vision consultants. Due to increased MCH funds appropriated by Congress, another consultant will be added to the staff of the Michigan Department of Health. The Committee wishes to express its thanks and appreciation to Goldie B. Corneliuson, M.D., Mr. Edmund Radke, Mr. Richard Murley, and Mr. Kenneth Mehr, of the Michigan Department of Health, for their work and cooperation with the Michigan State Medical Society.

On June 10, 1964, the Committee met with R. G. Rice, M.D., Medical Director of the Michigan Crippled Children Commission, and reviewed the Commission's reports on the Prevention of Blindness Program. A motion was adopted by the Committee that the Prevention of Blindness Program of the Michigan Crippled Children Commission is meeting a need and should be continued.

Two of the Committee's members, appointed as liaison to the Michigan Crippled Children Commission, will work with Doctor Rice on the matter of fee schedule and the simplification of their various reporting forms.

In reviewing a Michigan Department of Health chart showing the number of pre-school children screened in Michigan and the percent of children referred in schools selected by socio-economic area, the Committee adopted the following motion: "That the Committee on Ophthalmology recommends that the University of Michigan School of Public Health conduct a research project on the high incidence of children who fail vision tests in the culturally deprived areas of metropolitan Detroit."

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of Sections 1 through 4.

The Reference Committee recommended the following substitute Section 5: "The Committee approves the principle of testing for phenylketonuria, but recommends routine testing by hospitals be postponed pending further information as to the time of the appearance of a positive test."

The Reference Committee recommended approval of Sections 6 and 7, and the approval of Section 8 with the deletion of the last paragraph of this section.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON DIABETES

W. M. LeFevre, M.D., *Chairman*

During the year, the Committee held two meetings, the first on October 2, 1963 and the second on February 26, 1964.

1. *1963 Detection Program.*—A joint letter from Frank S. Perkin, M.D., Medical Director of the Michigan Diabetes Detection Program, and William M. LeFevre, M.D., Chairman, Diabetes Committee of the Michigan State Medical Society, was mailed to every member of the Michigan State Medical Society prior to the 1963 Diabetes Week (November 17-23). The letter supplied information and pamphlets of value to the individual doctor and asked for his cooperation and help in checking diabetes.

2. *Proposed Study on Standardizing of Blood Sugar Testing Techniques.*—A proposed study was thoroughly reviewed by members of the Committee and various recommendations were made to The Council of the Michigan State Medical Society. The Council disapproved the Committee's recommendations because the study would involve medical scientific practice standards, and as a matter of principle, the

Michigan State Medical Society does not establish such standards.

3. *Policy of the Michigan Department of Health in Diabetes Detection.*—The following statement was presented to the Committee by John A. Cowan, M.D., Director of the Division of Adult Health, Michigan Department of Health:

". . . the Michigan State Health Department is interested in the program which will see that all previously undetected cases of diabetes are brought to light and referred to their personal practicing physician for diagnosis and any indicated treatment. We believe that our purpose is to assist in detecting these individuals and seeing that they get a medical diagnosis and treatment by their own physician. Our policy is to assist in these detection activities but it is not our job to do either diagnosis or treatment."

4. *Relationship with Osteopathic Physicians in Hospitals.*—The Committee's recommendation that a final determination on the matter of associating ethically with osteopaths would have to be made, not by the Michigan Diabetes Association, but individually by each county medical society, was referred by The Council of the Michigan State Medical Society to the MSMS Committee on Medicine and Osteopathy.

Your Committee has worked in close cooperation with the Michigan Diabetes Detection Program of which MSMS is a sponsor. This program has resulted in 350,000 people being tested for diabetes in the past five years, 4,000 of whom were found to be previously undiscovered diabetics. This number amounts to 20% of all the detection done in the nation—done by a state that represents only 5% of the national population.

Your Committee recommends that MSMS and its component county societies continue to sponsor this Detection Program.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of this annual report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON ETHICS

H. W. Porter, M.D., *Chairman* (deceased)

No meeting of the Ethics Committee was necessary during the committee year. Questions and advice regarding interpretation of ethics were handled by the Chairman through correspondence.

The Committee sorrowfully reports the death of Horace W. Porter, M.D., Chairman of this Committee for ten years. Doctor Porter had a deep and abiding interest in preserving the high ethical standing of the medical profession, and generously devoted his time and knowledge to this Committee and to the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended acceptance of the annual report with tribute to the late H. W. Porter, M.D., the Committee's long-time chairman.

THE HOUSE adopted the report of the Reference Committee.

GERIATRICS COMMITTEE

A. Hazen Price, M.D., *Chairman*

The Geriatrics Committee held three meetings during the past year—one in Lansing and two in Ann Arbor. Each time a majority of the members were present with good discussion on a variety of subjects presented.

Considerable interest was manifest in the AMA and Nursing Home Association's effort to develop a program for Nursing Homes Accreditation. Reports were presented from the AMA on the national scene with good acceptance of the plan in most areas. An effort was made by various county committees on aging to interest Michigan nursing homes in the program with good reports from several areas. Michigan has more homes accredited than any other state, up until this time.

The State Commission on Aging was given a mandate by Governor Romney to develop a 10-year program for the aging in Michigan. Several members of our Committee participated in the Health Task Force's report to the Governor at a July 1 meeting in Ann Arbor. This is a very comprehensive report and contained many worthwhile recommendations. Doctor Getting, of our Committee, was responsible for formulating the many parts of the report.

During the Michigan Clinical Institute last March, the Committee developed a public forum program, "When Our Parents Get Old." Doctor Steincrohn, the *Detroit Free Press* medical columnist, was the principal speaker. Doctor Rom, of our Committee, was the moderator with two other members participating on the panel. An audience of 300 persons was present and many entered into the question-and-answer period. This was generally felt to be a very worthwhile public relations effort.

This next year several members of our Committee plan articles for submission to the Michigan State Society Journal. In addition, it is hoped we may participate in the state postgraduate program of the two schools of medicine in our State.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., chairman, recommended approval of this annual report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON HIGHWAY ACCIDENT PREVENTION

John R. Rodger, M.D., *Chairman*

There were two meetings of the full committee and one meeting of a subcommittee during the past year. Discussion of mutual problems was held with representatives from the Driver Licensing Division of the Secretary of State's office, and from the Michigan Safety Commission.

Medical standards were drawn up for suggested changes in Michigan's chemical tests for intoxication legislation, and some of these were incorporated in the legislation passed by the Legislature. The two changes of most interest to the medical profession were: first, that breath tests are now legal, and these can be made by a trained police officer, thus relieving the individual doctor from having to take them, and second, where a blood test is still necessary or the facilities for breath tests are not available, a trained nurse or lab technician may do so on the order of a doctor. Until this change it was necessary for the nurse or technician to do so under the personal supervision of a physician. Now a phoned order is all that is necessary.

A joint meeting was held of the Committee on Highway Accident Prevention and the Committee on Alcoholism and Drug Addiction to explore possible changes in the law in the treatment of the chronic alcoholic who is also a traffic offender. As a result of this meeting, subcommittees of both committees met with representatives of the state Bar Association. A fruitful conference was held, but as yet no definite proposals have been arrived at.

Two members of the Committee attended and took an active part in the AMA regional workshop on driver licensing held at Urbana, Illinois, in November. One member presented a paper on "Your Patient Who Should Not Drive" in the postgraduate course on therapeutics given at the University of Michigan Medical Center in the spring, which paper has been accepted for publication in the University of Michigan Medical Center Journal.

The Chairman of the Committee was appointed in the summer to the Governor's Special Committee on Traffic Safety, representing MSMS.

The members of the Committee were active in matters of traffic safety in their own county medical societies and local communities. Numerous safety problems were discussed in the meeting of the Committee on which no official action was taken.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON IODIZED SALT

B. E. Brush, M.D., *Chairman*

A meeting of our Iodized Salt Committee was held on Tuesday, March 24, in Ann Arbor, and plans were made for the coming year. Our Committee is very enthused about the numerous projects which we have planned for some time and which now seem to be in the final stages of accomplishment.

We are working in several areas among which are: An up-to-date survey of the proportion of iodized salt to non-iodized salt sold in stores in Michigan, a movie showing the problems with endemic goiter in Michigan, and plans to reach the various health agencies with our message.

We are now working more closely with the Salt Producers Association and have awakened renewed interest on their part to aid in this important project.

The results of the school surveys, done under the direction of Dr. J. K. Altland, will soon be released. We feel that the results will give an important stimulus to our work. Dr. Altland, of the State Health Department, continues his important support of our projects.

Our Committee is hoping to have all of its evidence in a presentable manner by this fall and then to declare a "Goiter Prevention Week" in order to call attention to the importance of endemic goiter.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of this annual report.

THE HOUSE adopted the report of the Reference Committee.

LEGAL AFFAIRS COMMITTEE

Otto K. Engelke, M.D., *Chairman*

The Legal Affairs Committee acknowledges with appreciation the outstanding support which the Committee has received from the members of the Society, thus making possible the completion of a highly successful legislative program during 1964. Many delegations from county medical societies visited with their lawmakers at the MSMS headquarters office and on several occasions the membership-at-large rendered invaluable assistance to the Committee. In addition, several individual physicians sacrificed of their time and gave of their knowledge in testifying before House and Senate committees of the Legislature.

The Legal Affairs Committee also acknowledges with thanks the thoughtful deliberations of the State Legislature regarding matters pertaining to health, and is cognizant of the deep interest of both that body and the Executive branch of state government that no action be taken which would be detrimental to the health care of the people of Michigan. Government officials gave courteous consideration to the viewpoints of MSMS.

While issues like apportionment captured the headlines, the Michigan lawmakers wrestled with nearly 100 bills of direct interest to medicine, and passed the four bills which stood at the top of the MSMS priority list for 1964. Particularly significant actions of the 1964 Michigan Legislature include:

Two bills, passed May 3 and effective July 1, 1964, will eliminate the old top fee and thus the fee schedule and codes of the Michigan Crippled Children Commission. Physicians and surgeons will henceforth be paid 80 per cent of the Michigan Uniform Fee Schedule for Governmental Welfare Agencies, 1959 revision.

The Crippled Children Commission in the future will use the Uniform Fee Schedule and its codes. Physicians should therefore bill according to the Uniform Fee Schedule code and its dollar amount listed—the Commission will reimburse at 80 per cent of that amount.

Top fees thus rise from a former $90.00 to $240.00 representing the first substantial improvement in the schedule since 1947 and culminating a four-year project by MSMS.

Applicants for the MAA program may now earn up to $1,900 per year single (was $1,500), and up to $2,700 per year if married and living together (was $2,500) and still qualify for benefits. This substantial improvement to the Medical Assistance to the Aged program is estimated to make over 11,000 additional medically indigent persons eligible for aid.

MSMS has long urged raising the income limits, and feels that Michigan's implementation of the Kerr-Mills federal law has been definitely strengthened.

The Old Age Assistance program for elderly persons who are hospitalized or in convalescent homes has been greatly improved. Cash grants to such persons have formerly been fixed at not to exceed $90.00 per month. These grants have now been increased to up to $140.00 per month.

Major legislation enacted as requested by MSMS includes a bill to permit "pooling" of risks by health insurance companies; "battered child" legislation incorporating desired immunity from liability for physicians; expansion of allowable tests for intoxication as endorsed by MSMS; a law requiring prescription for purchase of paregoric but permitting telephone prescribing; and a law protecting the confidential nature of data submitted to the Health Commissioner for research purposes.

The 96 major health-related proposals before this session of the State Legislature may be classified into several categories of priority. Several bills were introduced relating to the same subject—in which case MSMS sought passage of the best proposal; many proposals introduced were opposed as not in the best health interests of the people; some bills were introduced which MSMS supported as supplementary to its own legislative program.

The following legislative proposals were considered by MSMS to not be in the best health interests of the public and were successfully opposed:

A redefinition (and major expansion of practice privilege) of chiropractic;

A bill which would have eliminated the right of medical staffs to determine practice privileges in hospitals;

A bill which would have eliminated the right of the medical advisory committee in certain hospitals to recommend professional standards to its lay board;

A bill which would have eliminated the "ability to pay" clause from the 1963 Community Mental Health Services Act;

A bill which would have required all health and accident insurance carriers to pay chiropractors for any services "legally" rendered under the chiropractic license law;

A bill to require a plebiscite before fluoridation of water supplies; and many others, including a proposal to require a lay majority of the Blue Shield Board; to permit psychologists to practice psychotherapy; to create a cancer quackery advisory committee to the State Health Commissioner with a chiropractic advisor member; a number of unsatisfactory versions of chemical test, paregoric prescription, and "battered child" bills; undesirable amendments to the Workmen's Compensation Act; and a bill to license and regulate the practice of hypnosis.

The State Legislature added nurses to coverage under the 1963 "Good Samaritan" Law, although MSMS testified that this was not a necessary action, there being no legal "nurse-patient" relationship similar to the doctor-patient relationship. The Legislature also passed one amendment to the Workmen's Compensation Law which, under certain conditions, would make heart and lung diseases compensable. Two proposals were introduced and the one which passed was preferred by MSMS.

A proposal introduced for purposes of reorganization of state government into twenty "principal departments" was introduced, passed the State Senate, but failed to pass the House of Representatives. This proposal, as it passed the Senate, would not have provided for a board or commission to head the new and expanding Department of Health, as requested by the Michigan State Medical Society.

The State Legislature, under the new constitution, has next session (1965) to complete this task. If it fails to do so, the Governor has authority to act during the following year. MSMS will continue to closely follow developments in this vitally important area.

No legislation inimical to the best health interests of the people of Michigan has been passed.

Much desirable legislation, endorsed and sought by MSMS, has been enacted into law.

Much undesirable legislation has been rejected by a thoughtful Legislature, which has given MSMS every opportunity to express its views.

Some bills, sought by MSMS, failed this year:

Repeal of the 1937 Basic Science Act; despite a joint statement of support for repeal issued by MSMS and the Michigan Association of Osteopathic Physicians and Surgeons, a suitable vehicle could not be found to legally accomplish this during the present session. Definite progress was made toward acceptance of repeal.

Declaring that the transfusion of blood is the performance of a service rather than the sale of a product; some progress made toward establishment of this principle.

The Legal Affairs Committee acknowledges with appreciation the work of the Legislative Agent and the MSMS staff during this complex session.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, Jr., M.D., Chairman, recommended approval of this report and thanked the Committee for its tireless energies and commended it and the members individually for this enduring patience.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MATERNAL HEALTH

W. W. Jack, M.D., *Chairman*

The Maternal Health Committee held three meetings during the past year which were extremely well attended by Committee members. The Committee has developed copy for two additional Desk Reference Cards, one on the use of Oxytocics, the other on Minimum Standards of Prenatal Care.

On May 14-15, the third Maternal and Perinatal Welfare Conference was held at Gull Lake, Michigan, with a record attendance of 92 persons. During the year, an offer of financial support for this annual conference was received from the Clara Elizabeth Fund of Flint, Michigan, and the 1965 conference is already being planned and will be held in Flint.

In cooperation with the Michigan Department of Health, the Regional Evaluating Committees are continuing their review of maternal deaths and much important data is being collected. Efforts are being directed toward the development of an effective means of studying perinatal deaths as a means of evaluating maternal and newborn care for Michigan mothers and their infants. In addition, the Michigan Department of Health has received support from the federal government for a program of considerable size in the Detroit metropolitan area that will aid in prenatal and postnatal care, as well as hospitalization in specific instances, with regard to patients in an area that has had an exceptionally high incidence of mortality.

The members of the Committee wish to thank the House of Delegates and the membership of the Michigan State Medical Society for support of the maternal health educational programs.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of this annual report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MEDICAL SOCIO-ECONOMICS

H. F. Falls, M.D., *Chairman*

The 1963 House of Delegates approved the recommendation of the Reference Committee on Reports of Standing Committees, which asked that The Council review the results of the Kalamazoo and Michigan Hospital Service Studies of Medical Care in physicians' offices. This matter was later assigned to the Committee on Medical Socio-Economics by The Council. These two studies received individual study and analysis by each committee member. The results of these individual efforts were consolidated when the committee met as follows:

Kalamazoo Study.—It was the consensus of the Committee that, in fact, only a small portion of this study concerned itself with the quality of care in physicians' offices, and this was limited to attitudes and opinions. The Committee agreed, however, that the study revealed many opinions of doctors, nurses and the public re aspects of medical care in Kalamazoo, which would be of great interest to organized medicine in Michigan. The Committee recommended the following which were approved by The Council:

(a) Recommended that revised copies of the Kalamazoo Study be reproduced and distributed to The Council, House of Delegates and other leaders of the Michigan State Medical Society.

(b) Recommended that Chairman Falls appoint a special study group, which after consulting with the Commission on Professional and Hospital Activities, and others, would ascertain the feasibility of developing a program to evaluate the quality of non-hospital medical practice.

This special study group was appointed and based upon its thorough investigation, the Committee has recommended to The Council that even though such a study is feasible, the estimated minimum cost of such a project ($75,000 to $100,000) would not be justified by the value received. The committee will, however, continue to watch with interest similar studies, which are being carried on in Utah and California, and will report on any significant findings.

Michigan Hospital Service Studies.—These studies describe the home-care project of the Michigan Hospital Service and the Detroit Visiting Nurse Association. The Committee recommended the following which were approved by The Council:

(a) Endorsement of the expansion of similar programs into additional communities throughout the state.

(b) Recommended that doctors must be alerted to the economic advantages of home care and also the importance of using ancillary personnel to the best advantage, thereby insuring the best quality of medical care with maximum efficiency. As a result of this recommendation, an article, "Bringing the Hospital Home," by Committee member, Sidney E. Chapin, M.D., was written for the July, 1964, issue of *Michigan Medicine*. The Committee congratulates Dr. Chapin for his fine work.

Chairman Falls has been appointed by The Council as MSMS Advisor to the Governor's Action Committee on Health Care. This committee, appointed by Governor Romney, is a result of one of the recommendations of the former Governor's Commission on Prepaid Hospital and Medical Care Plans. Recognizing the tremendous amount of work involved in this assignment, your Socio-Economics Committee expresses appreciation to Dr. Falls for his efforts on behalf of MSMS.

The MSMS Department of Medical Socio-Economics, staffed by Richard M. Campau, Research Director, and Clyde T. Hardwick, Ph.D., Economic Consultant, has had a busy and productive year. The Department continuously filled requests for data by MSMS Councilors, Officers, Committee Chairmen, and others. The department was also engaged in special activities, which are highlighted below:

Consultation with MSMS Headquarters.—Dr. Hardwick, at the request of The Council, consulted with the new MSMS Executive Director and Associate Executive Director in the formulation of the new MSMS Headquarters reorganizational plan.

MSMS Testimony before the House Ways and Means Committee.—The Department assisted in the drafting of the MSMS presentation to the Ways and Means Committee of the U. S. House of Representatives, which was presented by Otto K. Engelke, M.D., Chairman of the MSMS Committee on Legal Affairs, regarding the proposed King-Anderson Bill. The Department also provided extensive backup material to aid in the presentation.

MSMS Legislative Matters.—The Department worked continuously with the MSMS Committee on Legal Affairs and the MSMS legislative agent to provide original and

factual research which would assist MSMS in its testimonies, both oral and written, presented to various committees of the State Legislature and other state agencies. We congratulate the MSMS Committee on Legal Affairs for its many legislative accomplishments during the year and we are pleased that the Economic Department had an important supportive role.

Profile of Medical Doctors of Michigan.—The Department, in close cooperation with the Circulation and Records Department of the American Medical Association, completed a basic research project, which makes available for the first time selective characteristic data on all doctors of medicine in Michigan.

From this data it is possible to ascertain the following information on each doctor in Michigan—name, address, sex, year of birth, information on medical education, first year of licensure in Michigan, medical specialty, American Specialty Board Certification, whether or not in private practice, AMA, state and county medical society membership.

Statistical summaries for a variety of purposes, heretofore unattainable, can be gleaned from this basic research project, such as the specialty distribution of MSMS members, which was recently prepared for the Committee on Professional Insurance Plans.

Economic Workshop.—The Department held its 5th Economic Workshop with one in Gaylord that included doctors from both the 9th and 10th Councilor Districts. This activity afforded those participating an opportunity to share viewpoints on many of the vital socio-economic issues which face the private practice of medicine. Future Workshops are contemplated for the areas of Detroit, Ann Arbor, and Grand Rapids, completing this project.

Improvement of Kerr-Mills Operation in Wayne County.—The Department performed original research for a special committee of the Wayne County Medical Society chaired by Wyman C. C. Cole, Sr., M.D. This committee's efforts brought about changes in the operation of Kerr-Mills which will enable more patients to receive care, under the Michigan Medical Assistance to the Aged program, from their personal physician.

Economic Section of the MSMS Journal.—The Department collaborated with the Managing Editor of the MSMS Journal to alert MSMS membership to important developments in the medical socio-economic field. Many original articles were supplied by the Department.

Additional Committees Assigned to the Department.—The Council approved the appointment of Mr. Campau as staff assistant to the following additional committees: Committee on Medicare, Committee on Professional Insurance Plans, Committee on Rehabilitation, Committee on Relative Value Study, and the Committee on Uniform Fee Schedule for Governmental Welfare Agencies.

Besides rendering necessary secretarial and clerical assistance, the department was able to provide its full resources and facilities in assisting these committees in their important work. An example of this is the questionnaire being used by the Committee on Rehabilitation in its Survey of Medical Facilities in Michigan for the Physically Impaired.

THE REFERENCE COMMITTEE on Reports of Special Committees, B. E. Brush, M.D., Chairman, recommended approval of this report with commendation to the committee and the recommendation that more consideration be given to long-term medical socio-economic trends which can be used to draft future policies of MSMS.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON MENTAL HEALTH

BENJAMIN JEFFRIES, M.D., *Chairman*

In one of its most active years, the MSMS Mental Health Committee has met seven times since the 1963 meeting of the House of Delegates. During this past year, while great emphasis has been placed upon mental health programs by both the U. S. Congress and the Michigan Legislature, MSMS has exercised leadership and shown initiative by conducting one of the most successful State Mental Health Congresses on Mental Illness and Health, by authorizing publication of an authoritative bulletin by its own Mental Health Information Center (A.I.D.), and by preparing to participate in the second National Congress on Mental Illness and Health to be conducted by the American Medical Association in November, 1964.

The Committee, during the past year, has intensively reviewed every piece of mental health legislation brought before the 1964 Legislature and made its recommendations through the MSMS Legal Affairs Committee to The Council. The Committee's Chairman, who serves as a gubernatorial appointee to the State Mental Health Advisory Council, attended the AMA's 10th Annual Conference of State Mental Health Representatives in Chicago in mid-February and based upon this conference the Committee developed its plans for the Michigan Congress on Mental Illness and Health.

During late June, in Detroit, over 300 mental health leaders from the laity and the professions gathered to hear four outstanding addresses and to participate in 13 discussion groups as MSMS conducted one of the most successful statewide mental health meetings yet held in the United States. A full transcript of this meeting is under preparation and has been requested by persons active in mental health activities all over Michigan. The Congress, designed to encourage medical leadership in mental health matters, was one of Michigan's outstanding 1964 medical meetings.

In 1963, the State Legislature passed a new law known as the Community Mental Health Services Act and since passage of this statute, voluminous administrative rules have been developed for its implementation. The Committee, in concert with the MSMS Legal Affairs Committee, has been instrumental in influencing the development of these rules under which this important program will operate. Fourteen Michigan counties are now commencing to implement this new program which emphasizes local prevention and treatment of mental illness as opposed to the institutional approach. The Community Mental Health Services Act promises to be one of the most significant pieces of medical legislation in many years, and the MSMS Mental Health Committee continues to keep abreast of each phase of its development.

During the past year, Committee members made an exhaustive and scholarly analysis of the organization of state governments throughout the nation, to determine what recommendations should be made to The Council of MSMS regarding the reorganization required by Michigan's new Constitution. After reviewing a lengthy analysis, it was recommended that the Michigan Mental Health Department be maintained as a separate principal department of state government and not co-mingled with any other state agency. The Council has expressed MSMS position to the effect that in a reorganized state government the mental health, public health, and health institutions functions should be grouped in a single agency with the mental health function not under, but parallel to, the public health function.

Developing its own Mental Health Information services so that both lay and professional groups will turn to medicine for authoritative information regarding mental health, the Committee obtained Council approval to publish a new MSMS bulletin called A.I.D. (Advice-Information-Data). The first issue of this publication, sent to lay and professional leaders on mental health programs in the communities of Michigan, contained sixteen pages of helpful information.

The Committee also cooperated with the State Department of Mental Health in making available to all physicians of Michigan an excellent booklet entitled "Mental Retardation: A Family Crisis—The Therapeutic Role of the Physician." It has been working toward the development of proper psychiatric service fees for incorporation in the Uniform Fee Schedule for Governmental Welfare Agencies, as this document is revised.

The stated purpose of the MSMS Committee on Mental Health is to study mental health and mental illness in Michigan and make recommendations to increase the awareness and understanding of this broad health problem by both the medical profession and interested segments of the public. The Committee, to carry out this charge, serves in a liaison

capacity with national mental health efforts, especially those of the American Medical Association.

To accomplish these stated responsibilities the President of MSMS has appointed a 25-member committee, all of whom have distinguished themselves in their fields of specialization. Represented on the committee are the special backgrounds of private practice, the major state mental health institutions, past and present mental health administrations, and mental health education.

This MSMS Committee, plus selected official representatives of the Michigan State Medical Society Council, official Michigan Government, designated representatives of the lay Michigan Society for Mental Health, Inc., and the professional Michigan Society of Psychiatry and Neurology, will represent the state of Michigan in early November, 1964, at the second National Congress on Mental Illness and Health. Insights and knowledge gleaned from this meeting will be put to use continuing to provide the necessary medical leadership in rapidly expanding mental programs in Michigan.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of this annual report with special recognition for a great deal of work on a difficult problem.

THE HOUSE adopted the report of the Reference Committee.

ADVISORY COMMITTEE TO THE MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

G. E. Millard, M.D., *Chairman*

This Committee held one formal meeting on March 12 following the attendance of the formal board meeting of the State Medical Assistants Society.

The educational system was discussed and it was decided to continue as the organization has been. They are making progress.

The officers of the State Medical Assistants Society, the undersigned, Dean Valade of the Highland Park Junior College, a representative of the Michigan State Vocational Rehabilitation Office; Mr. Gordon Hanna, a representative of MESA, and several others have set up a pilot program which is to be taught at Highland Park Junior College for the employable unemployed. This will be financed in great part by the federal government. At this moment, we do not know or cannot predict the future of this type of education.

Through the efforts of the State Medical Society, the Medical Assistants Society and many others the bill to regulate nursing has been modified so as not to interfere with the employment of medical assistants by the physician.

The Medical Assistants Society will very shortly have a space allocated for its use in the State Medical Society headquarters.

I wish to thank the members of this Committee for their great interest in the promotion of this most worthy medical organization.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of this report, further recommending that MSMS members encourage their employees to become members of the Medical Assistants Society.

THE HOUSE adopted the report of the Reference Committee.

OCCUPATIONAL HEALTH COMMITTEE

E. A. Irvin, M.D., *Chairman*

During the past year, two meetings of the Occupational Health Committee were held—September 10, 1963 and July 7, 1964.

A resolution on "Small Plant Medical Services" was presented to the House of Delegates of the Michigan State Medical Society with no action.

A resolution on a "Standard Disability Form" was presented to the House of Delegates of the Michigan State Medical Society with no action.

The Committee prepared a series of articles on Occupational Health which are now appearing in every second issue of *Michigan Medicine*.

The Committee is exploring the possibility of having a joint study group to establish a closer relationship between the Michigan State Dental Association and the Michigan State Medical Society in handling dental problems in employed groups.

A sub-committee has been appointed to study and make recommendations in regard to the detection of emotional disturbance in prospective employees.

A report on the legal status of non-professionals rendering first aid was presented to The Council of the Michigan State Medical Society with recommendations to have this distributed to the MSMS membership, employers, workmen's compensation insurance carriers, and members of the Michigan State Association of Industrial Nurses.

A report was presented to the Committee of currently available plans for prepaid dental care.

Dr. Joseph Schaefer was nominated to The Council by the Committee as a possible candidate for the President's Award on Employment of the Physically Handicapped.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended deletion of paragraph five and paragraph eight, because they were foreign to the purpose of the Committee, and approval of the annual report as amended.

THE HOUSE adopted the report of the Reference Committee.

ADVISORY COMMITTEE OF PAST PRESIDENTS

C. I. Owen, M.D., *Chairman*

This committee met September 26, 1963, with an attendance of 11. Louis J. Hirschman, M.D., was named Honorary Chairman and C. I. Owen, M.D., Acting Chairman.

The passing of Milton A. Darling, M.D., and Wilfrid Haughey, M.D., was recognized.

The Health Fair and Centennial of 1965 were discussed and recommendations calling for participation by many M.D.s (up to 500) as demonstrators at the Health Fair were made.

The Committee recommended to The Council that a more formal induction ceremony of Presidents in the future be given serious consideration.

THE REFERENCE COMMITTEE on Reports of Standing Committee, H. W. Harris, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

POSTGRADUATE MEDICAL EDUCATION COMMITTEE

John M. Sheldon, M.D., *Chairman*

The Committee on Postgraduate Medical Education met on July 18, 1963, January 16, 1964, and August 6, 1964, and reviewed the postgraduate program. The reports from postgraduate center chairmen, as well as other physicians, have been presented to the Committee. Much of the deliberation of the Committee has centered around the response in the various centers to the program, including comments and suggestions received about the type of presentation, number of programs, and subject material desired.

The Committee feels that the 1963-64 postgraduate program has been a satisfactory one. Great effort has been made to offer subjects of primary interest to the physicians in the centers, and to obtain outstanding speakers whenever possible. The Committee seeks constantly for suggestions of subjects that the centers would like to have presented. In order to increase the scope of the presentations, lists of subjects for the programs have been sent to the chairmen of the meetings. The desire for panel type discussions has been expressed by many physicians and such type of programs have been implemented in several instances.

A representative for your chairman has visited personally many physicians in their offices in the State in an attempt to learn their wishes for the improvement and expansion of the program. The information obtained promises to be most

helpful in future planning for the location of centers, hours of meeting, type of presentation, subject material, etc.

The subjects presented, attendance, and speakers on the Fall and Spring program were as follows:

Centers	*1963 Fall*	*1964 Spring*	*Different Doctors at the 2 Sessions*
Alpena	20	18	22
Battle Creek	61	37	82
Bay City	....	32	32
Cadillac	....	23	23
Grayling	15	14	19
Grosse Pointe	73	...	73
Jackson	56	47	68
Lansing	83	29	89
Midland	33	61	68
Muskegon	63	63	86
Niles	42	27	54
Petoskey	17	22	32
Port Huron	....	29	29
Traverse City	46	....	46
Upper Peninsula			
Escanaba	16	16	20
Houghton-Calumet	11	13	20
Iron Mountain	17	8	17
Ironwood	9	11	13
Marquette	....	32	32
Menominee	27	23	28
Sault Ste. Marie	19	16	24
	608	521	787

During the year, the following subjects were presented on this program:

Fall

Acute Abdomen in Children
Blood Dyscrasias
Carcinoma in Situ of the Female Genital Region
Common Errors and Misconceptions in the Use of Parenteral Fluids
Common Obstetrical Problems
Common Urological Problems
Coronary Heart Disease
Diabetes
Hereditary Diseases of Childhood and Errors of Inborn Metabolism
Muscular Weakness Syndromes
Neurology
Ophthalmic Problems of Interest to all Physicians
Staphylococcus Infections
The Legal Implications of Mysterious Deaths and Injuries
The Medical and Surgical Management of Cerebro-Vascular Accidents

Spring

Carcinoma in Situ of the Cervix in the Pregnant and Nonpregnant Female
Current Concepts of Pulmonary Disease
Dialysis in Renal Disease
Diseases of the Major Salivary Glands
Hirsutism in the Female
Modern Trends in Immunization
Muscular Weakness Syndromes
Office Proctology
Recent Advances in Cardiology
Shock
The Acute Abdomen
The Medical and Surgical Management of Diseases of the Pancreas
The Role of the Community Hospital in Postgraduate Medical Education
Treatment of Staphylococcus Infection

Physicians who participated in the program were: Drs. David G. Anderson, Samuel J. Behrman, Bernard A. Bercu, Ernest M. Berkas, Robert E. L. Berry, Richard J. Bing, Robert J. Bolt, Joseph C. Cerny, William W. Coon, Arthur C. Curtis, Marion S. DeWeese, David G. Dickinson, Harold F. Falls, F. Bruce Fralick, Andrew A. Freier, A. James French, William J. Fry, John Gilroy, E. Richard Harrell, Robert C. Hendrix, Joseph W. Hess, William N. Hubbard, Richard C. Juberg, Richard O. Kraft, A. Martin Learner, Ralph R. Margulis, Richard S. McCaughey, Barbara A. Mella, Raymond W. Monto, George W. Morley, Reed M. Nesbit, Gerald A. O'Connor, Lawrence Power, William D. Robinson, John M. Sheldon, Norman W. Thompson, Harry A. Towsley, A. Burgess Vial, James L. Wilson, William S. Wilson, Walter P. Work, George D. Zuidema, Andrew J. Zweifler.

Intramural Courses at the University of Michigan	*Attendance*
Allergy	27
Anatomy	22
Basic Sciences and their Clinical Correlations	220
Cardiac Resuscitation	22
Clinical Internal Medicine	63
Dermatology	71
Diseases of the Blood	17
Diseases of the Heart	42
Electrocardiographic Diagnosis	44
Electrocardiography and Heart Disease	71
Endocrinology and Metabolism	37
Infertility and Endocrinology	51
Interns and Residents	414
Neurology, Clinical	31
Nuclear Medicine	55
Obstetrics and Gynecology	77
Ophthalmology	129
Otorhinolaryngology	39
Pathology Slides, Surgical	10
Pediatrics	61
Physical Medicine	46
Physiology	18
Prothrombin Testing	19
Psychiatry	24
Pulmonary Diseases	29
Radioactive Isotopes, Clinical Use of	17
Radiology, Diagnostic	35
Rheumatology	20
Pediatric Neurology	49
Selected Clinical Topics	14
Therapeutics, Recent Advances in	74
Recent Advances in Basic Mechanisms of Internal Medicine	121
Merck, Sharp & Dohme Conference (Virus Disease)	419
	2388

The Committee is very appreciative of the services of the many physicians who have participated in this teaching program, and for the support and encouragement given the program by the Michigan Department of Health, the Wayne State University School of Medicine, and the University of Michigan Medical Center.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of the annual report, calling the attention of the House to the great amount of time and effort devoted to this program by the physicians who participated in the program, members of the Committee, and especially Dr. John M. Sheldon, its long-time Chairman.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON PROFESSIONAL INSURANCE PLANS

M. D. MacQueen, M.D., *Chairman*

The Committee held meetings on October 17, 1963, October 30, 1963, January 15, 1964, and February 19, 1964.

Important Committee activities are highlighted below:

1. *Improvements in the MSMS Group Sickness and Accident Policy.*—The Committee was successful in gaining the following improvements for MSMS sickness and accident policyholders, effective November 15, 1963:

(A) Benefits for total disability resulting from accident were extended from five years to lifetime for disabilities commencing prior to age 66.

(B) Benefits for total disability resulting from sickness were extended from two years to five years for disabilities commencing prior to age 66.

(C) Weekly indemnity amounts were changed to monthly indemnity as follows: $50 weekly changed to $215 monthly; $75 weekly changed to $325 monthly.

(D) The Waiver of Premium provision was changed to cover entire period of continued disability even if this extends beyond the period of compensable disability.

(E) Air travel restrictions were eliminated except for accidental loss of life or members. These restrictions were also liberalized for accidental loss of life or members.

(F) Partial disability for sickness was liberalized. This was formerly only payable after payment of benefits for total disability from sickness for at least 30 days. This is now payable after period of total disability from sickness for seven days or more.

(G) New optional benefits are also available. Sickness disability benefits may be extended to those who are eligible from five years to age 65. Also monthly indemnity may be increased for those eligible to $400 or $500.

2. *Proposal of Major Medical Insurance for MSMS Members.*—As instructed by the House of Delegates and The Council, the Committee completed its study of the best possible major medical plan for MSMS members, which in the opinion of the Committee is in accordance with MSMS policy. A plan offered by Health Service Incorporated and Medical Indemnity of America, which is to be serviced by Michigan Medical Service, has been submitted to The Council for approval.

3. *Program of Business Overhead Expense Insurance for MSMS Members.*—The Committee has under active study several plans of business overhead expense insurance for MSMS members.

4. *Program of Professional Liability Insurance for MSMS Members.*—The Committee has under active study several plans of professional liability insurance for MSMS members.

5. *Travel and Accident Insurance for MSMS Officers and Staff.*—The Council has implemented such a program as previously recommended by the Committee.

6. *Liaison with the Michigan Chapter of the Health Insurance Council.*—As previously recommended by the House of Delegates, the Committee has continued its liaison with the Michigan Chapter of the Health Insurance Council. An annual meeting was held on February 19, 1964, and has continued the harmonious relationship between our two groups. A recommendation has been made to The Council that a portion of next year's Public Relations and County Secretaries' Seminar be reserved for the purpose of inviting representatives of the Health Insurance Council to discuss matters of mutual interest with secretaries and other leaders of the county medical societies.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of this annual report.

THE HOUSE adopted the report of the Reference Committee.

PUBLIC HEALTH INTERIM COMMITTEE

O. D. Stryker, M.D., *Chairman*

The Interim Committee on Public Health was appointed by the President of MSMS to function during the year 1963-1964 as a temporary committee pending official action of the House of Delegates to implement the recommendations set forth in the 1962-1963 Annual Report of the Public Health Committee. Delegates will note that MSMS Bylaws amendments are now proposed by the Constitution and Bylaws Committee for adoption at the 1964 House of Delegates which will redefine the MSMS Public Health Committee.

The Interim Committee gave specific consideration to the implementation of Resolution No. 48 of the 1963 House of Delegates dealing with cigarette smoking. After participation by MSMS in a number of conferences relating to the hazards of smoking, particularly among youth, and after proposals had unsuccessfully been made by the Michigan Department of Health to the state legislature for funds to conduct educational programs in this regard, a joint project was undertaken by several voluntary health agencies, plus public health and education groups, to develop a Teaching Guide on Smoking and Health for use in the elementary and secondary schools of Michigan. The Society cooperated in this endeavor and proudly notes that H. J. VandenBerg, Jr., M.D., Chairman of the MSMS Committee on Cancer Control, is serving as Chairman of the new Interagency Council on Smoking and Health. This Council which functions within the structure of the Michigan Health Council, is undertaking programs which implement Resolution No. 48 of 1963.

In connection with smoking and health, the Committee recommended a policy adopted by The Council, MSMS, that "the medical profession take action to discourage cigarette smoking both by precept and example."

The Interim Public Health Committee also recommended MSMS Council approval, which was given, of an immunization policy developed by The Michigan Department of Health regarding oral polio vaccine and this was widely publicized to component county societies.

In the future, it is contemplated that the newly constituted Public Health Committee will be able to serve The Council and membership of MSMS by receiving and considering questions from the component county societies concerning public health, as well as reviewing specific programs which are being planned or undertaken by the Michigan Department of Health.

THE REFERENCE COMMITTEE on Hygiene and Public Health, E. C. Baumgarten, M.D., Chairman, recommended approval of the report, with encouragement to the Committee to continue its efforts to achieve the objectives set forth in the report.

THE HOUSE adopted the report of the Reference Committee.

PUBLIC RELATIONS COMMITTEE

R. W. Teed, M.D., *Chairman*

Under the direction of the Public Relations Committee, MSMS has conducted a comprehensive public informational program to demonstrate the concern of the physician for the public welfare, and to increase public understanding of the professional principles which govern the work of the practicing doctor of medicine.

The MSMS Public Relations Committee is constantly aware of the person-to-person aspects of good PR; and the Committee seeks also to take the leadership in interpreting MSMS service projects through all comunications media.

Obviously, MSMS public relations activities are diverse, varied, complex and not all carried out by the PR Committee. Good examples of these are the MSMS activities in such related fields of legislation, scientific work, postgraduate education, etc. However, the PR Committee constantly seeks to improve and interpret the PR aspects of such projects to the various publics that are involved. Doctors are anxious to be better understood by their patients, their para-medical associates, legislators, communication media personnel, educators, etc.

PR Leadership Training

Some of the work of the PR Committee each year is in the form of "PR Leadership Training." The skills and understandings of many physicians in this area must be enlarged and improved further. Some of the major efforts in the PR leadership field included the following:

1. *Annual County Secretaries Public Relations Seminar.*—This event was held in Lansing on February 27, 1964, and outdrew the attendance of any previous year. Vital topics were covered. F. J. L. Blasingame, M.D., AMA Executive Vice President, led the "faculty." The project was expanded with meetings the night before of the PR Committee, Legal Affairs Committee, County Medical Society Bulletin Editors and new County Society Secretaries.

2. *PR Articles in Michigan Medicine.*—Articles counseling and assisting doctors with PR matters are carried regularly in Michigan Medicine.

3. *Liaison with County Society PR Programs.*—Much of the PR leadership activities carried on between the MSMS Committee and local component societies are through members of the MSMS Committee and staff. Deliberately, the Committee is representative of many counties, to provide easy channels up and down for maximum cooperation.

4. *News Media Dinners.*—These dinners are typical of the many projects which are both PR leadership with county society leaders, and direct PR projects with selected audiences. As MSMS conducts these dinner meetings for media representatives, considerable joint planning is carried out with the county officers and county PR chairmen. The

follow-up activities provide further opportunity for close, cooperative action with the communications media.

PR Projects Designed for Special Audiences

All good public relations programs should be thoroughly planned, some with special-interest people, and others broadside at the general public—but each is deliberately planned and executed. Following are highlights of some of the MSMS special-audience public relations programs:

1. *News Media Dinners.*—See comments above under #4. These meetings will be continued.

2. *Liaison with Specific Groups.*—Although not the direct function of the PR Committee, valuable liaison is carried on throughout the year with several distinct publics. These include the leaders in state government, the pharmacists, the hospitals, the attorneys, educational institutions, etc.

3. *Inter-Professional Liaison.*—Perhaps one of the major accomplishments of MSMS in recent years has been the expansion of its effective relationships with the other professions. The Michigan Association of the Professions provides this unique relationship with the seven other professional groups in this movement. Through its publications, its annual Congress of the Professions, *et al,* MSMS members work hand-in-hand with the other professional men and women in programs of legislation, public relations, career recruitment, etc.

The establishment of the Michigan Health Council by MSMS and its continuing support provides many inter-professional liaison opportunities. Cooperative projects by the doctors of medicine with the other health professional people through the Health Council enables all of us to more effectively recruit health careerists, to stress the importance of preventive health measures, etc. A fine example of inter-professional liaison through the Michigan Health Council is the Placement Service, which effectively matches up communities which want doctors of medicine, doctors of dentistry, and doctors of veterinary medicine and the professional people who are seeking communities to practice in.

4. *"Medical Journal."*—This weekly radio series over WDTM-FM and several other FM stations in Michigan is a scientific educational program for doctors and para-medical personnel. Primarily a technical program offered by a group of physicians on the Wayne State College of Medicine faculty, it does have public relations aspects, and is a good example of the communications project with a clearly-defined target.

PR Projects Reaching the General Public

Although some of the above mentioned projects may be limited in scope, they did have some general public implications. Other projects were primarily developed to reach the public.

MSMS Annual Awards Luncheon.—This event was a highlight of the annual County Secretaries-Public Relations Seminar, February 27, 1964. MSMS presented a total of 35 awards to deserving recipients. The number may seem high, but is better understood when it is realized that the awards were for organizations and individuals in eight categories. Awards were given to distinguished Michigan physicians, to Michigan physicians serving national medical organizations as president, to legislators, to newspapers, radio and television organizations and individuals, and to Michigan civic workers. This year, six were given to foundations who have played major roles in the medical-health field in Michigan.

News Media.—News releases to all Michigan newspapers, radio, and TV stations were processed to report the work and policies of MSMS to the general public. In addition to the year-round work in this field, concentrated news work was carried out at the 1963 Annual Session in Grand Rapids and at the 1964 Michigan Clinical Institute in Detroit. (The News Media Dinners were covered previously in this report.)

Radio Audiences.—Through its Committee on Scientific Radio and Television, MSMS each year develops radio tapes with the University of Michigan on topics of general health. These are then aired weekly by 38 stations in Michigan, Canada and Ohio. The report of that Committee provides the details. Many people, especially in the Detroit metropolitan area, heard a physician discuss a health question on the daily "Health Call" segment over WWJ. This project is a cooperative effort of the Wayne County Medical Society and MSMS.

Television Audiences.—MSMS is proud of the two excellent weekly television programs produced by the Michigan Association of the Professions. The program, "Decision, The Moment of Truth" over WJBK-TV, Detroit, was shifted during the year to the prime time of 12:30 p.m. on Sundays. During the year, a second weekly series, entitled "Formula," was launched April 15 over WJIM-TV in Lansing at the popular time of 8:30 p.m. Wednesdays. Both of these programs have interpreted many health topics and have featured many doctors of medicine. By actual count, thirty-three physicians have participated in the informative programs over WJBK-TV and WJIM-TV. The public relations value of these programs is tremendous, when one realizes that each week the two programs reach a combined audience of more than 250,000.

Occasionally, MSMS has helped to develop a television program for some station on a health topic, and more often MSMS might help a television producer find a doctor for a feature presentation or a news interview.

Community Projects.—The major new project during the past year was the "Community Health Week" effort, conducted by AMA across the nation and by MSMS in considerable depth here in Michigan. Thanks to the excellent cooperation of the Michigan Health Council and the Michigan Association of the Professions, there were statewide public relations efforts such as news releases, television programming, a proclamation by Governor Romney, etc., and much local work by county medical societies. Perhaps the most common local activity was the presentation of career programs at the school or hospital.

Motion Pictures.—Progress was made toward the preparation of a special film planned for use in connection with the MSMS Centennial observance. The distribution of films for use at school programs, noon luncheon clubs, PTA meetings, etc., continues with more than 25 different films available from AMA and other sources through the MSMS Public Relations Library Service.

Speakers.—Speakers were provided almost every week for schools, colleges, service clubs, ancillary groups, ladies' organizations, etc., to discuss a variety of medical subjects. Once again, there was a growing interest in medical speakers on socio-economic subjects. MSMS officers, staff members and committee chairmen have been generous with their time —and dedicated efforts are carried on at the local level by the component county medical societies, the woman's auxiliary, the medical assistants society, and other ancillary groups.

Pamphlets and Publications.—No accurate estimate is available of the thousands and thousands of pieces of literature on a wide range of subjects distributed to the public through the determined efforts of physicians. Many doctors get some of these materials direct from the AMA and each day requests are filled by MSMS for booklets and folders about arthritis, quackery, health insurance, etc. For example, in August, MSMS distributed more than 340,000 pamphlets about cancer alone. Much attention was focused on literature related to the Kerr-Mills and King-Anderson subjects. The MSMS booklet, "Planning Your Career as a Medical Associate," continued to be one of the most widely-requested pieces for use in schools and youth groups.

"Operation Hometown."—This program may be covered also in the report of the MSMS Legal Affairs Committee—and rightly so. Although designed to help the county medical societies and the MSMS in its campaign to resist socialized medical legislation, the program also has served to project the doctor as an active, concerned community worker and civic leader.

In closing, the Committee again wishes to stress the importance that every individual doctor and every medical organization continue "to do good and to tell people about it." Good public relations must be earned and maintained.

MSMS continues to be on the alert to develop meaningful programs and to assist component medical societies and individual doctors with techniques and materials.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., Chairman, reported: "The activities of this Committee are diverse, complex, and time-consuming. The importance of person-to-person interpretation of our activities cannot be over-emphasized. This Committee is charged with making doctors better understood by their patients, associates, paramedical personnel, legislators, newsmen and educators. We commend this Committee for its activities on our behalf and recommend approval of the report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON RURAL MEDICAL SERVICE

R. E. Rice, M.D., *Chairman*

The Committee on Rural Medical Service met at MSMS headquarters on June 11, 1964.

John Doherty of the Michigan Health Council displayed an advertisement that appeared in the "New Physician," a Student American Medical Association publication. Over fifty inquiries were received from all over the nation. This advertisement is currently being run in the Michigan Health Council publication. The committee was favorably impressed by the potential of the advertisement and recommended that the MSMS cooperate with the Michigan Health Council in placing an advertisement in the "New Physician" at intervals during 1964-65. This recommendation is now being considered by the Finance Committee of The Council.

The committee chairman reviewed the highlights of a report to The Council of his attendance at the National Conference on Rural Health at Columbus, Ohio, in March, 1964. This was an outstanding conference dealing with the many problems that are involved with the shift of population from the cities to the suburban areas. The cooperation of the medical profession along with many other interested and well-informed lay groups is necessary in working toward a solution of these problems.

Community Health Week, which will occur in October, was discussed by the Committee. The format of this year's Community Health Week will be similar to last year's but enlarged upon to include open house in hospitals and rehabilitation centers and more emphasis on careers in all phases of therapy. The Committee adopted a motion to cooperate fully in promoting Community Health Week.

Dr. R. W. Spalding from Allegan presented a resolution as follows:

Whereas, there are not sufficient physicians to replace the general practitioner and,

Whereas, specialists will not replace the need for general practitioner services and,

Whereas, medical students have little or no contact with G.P.'s and,

Whereas, the community hospital plays an important role in the decision for location of practice, therefore, be it

RESOLVED, that this committee recommend the following actions: (1) That preceptorships be established in community hospitals where the practice of the generalist could be observed firsthand; (2) That draft deferment be offered to recent graduates who are willing to locate in rural communities in urgent need of medical care; (3) That study be given to the promotion of better, active consultation services in rural community hospitals, where necessary, by representatives of the specialties.

Committee comment indicated a general agreement meriting attention of The Council. It was suggested that medical school approval was needed as well as analysis and advice by John M. Sheldon, M.D., H. A. Towsley, M.D., and others. A request for staff research on what other states are doing along these lines and also to ascertain the M.D. draft deferment information was suggested.

A fall meeting of the committee is planned relative to its participation in Community Health Week.

The chairman wishes to express his thanks to the members of the committee for their participation in this year's work.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of this report, and recommended that the Committee be empowered to further explore the recommendations embodied in the Resolved portion of the resolution contained in the annual report.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON SCIENTIFIC RADIO AND TELEVISION

G. H. Lowrey, M.D., *Chairman*

The Scientific Radio and Television Committee held its annual meeting on June 26, 1964.

We are pleased to report that in 1963-1964, the WUOM Scientific Program, "Prescription for Health," was offered to subscriber stations on a 52-week basis. Twenty-nine stations elected to carry the weekly program on a year-round basis. Six additional stations broadcast the program on a nine-month basis (September to June). Emphasis is being placed on panel-type programs (as opposed to single-speaker type programs.)

The decision to discontinue distribution of the program in printed form was implemented without objection from any source.

Last year's decision to supplement the regular 15-minute program with a series of 5-minute taped broadcasts was not implemented, but a determination has been made this year to appoint a member of this Committee as project coordinator for the abbreviated program. It is anticipated that work on the 5-minute programs will begin in early fall, following final review and approval, by The Council of MSMS, of program plans.

The Committee re-emphasized its previous decision to include appropriate non-scientific material as subject matter for both the 15- and the 5-minute series.

It was the consensus of Committee members that participation in these programs not be limited to physicians in the Ann Arbor area, but that any qualified physician, willing to travel to Ann Arbor for a recording session, should be considered.

Stations Subscribing to "Prescription for Health"

WOWE-AM	Allegan	WMTE-AM	Manistee
WLEW-AM	Bad Axe	WAGN-AM	Menominee
WELL-AM	Battle Creek	WDMC-AM	Otsego
WATT-AM	Cadillac	WOAP-AM	Owosso
WCAR-AM	Detroit	WMBN-AM	Petoskey
WJBK-AM	Detroit	WHLS-AM	Port Huron
WKAR-AM	East Lansing	WHAK-AM	Rogers City
WMRP-AM	Flint	WMIC-AM	St. Helen
WTAC-AM	Flint	WSJM-AM	St. Joseph
WGRD-AM	Grand Rapids	WIOS-AM	Tawas City
WJEF-AM	Grand Rapids	WABX-FM	Detroit
WLAV-AM	Grand Rapids	WLDM-FM	Detroit
WHMI-AM	Howell	WQRS-FM	Detroit
WKZO-AM	Kalamazoo	WKLW-FM	Grand Rapids
WMRT-AM	Lansing		

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of the report and further recommended that the Committee explore the possibility and cost of video-taping these live programs so that they may be reproduced for component societies not served by the live programs.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON VENEREAL DISEASE CONTROL

R. L. Mainwaring, M.D., *Chairman*

The Committee met on June 16, 1964, and reviewed annual reports, minutes, and MSMS House of Delegates' actions regarding venereal disease, since 1960.

The following information was reviewed and is hereby submitted for the information of the 1964 MSMS House of Delegates:

1. The Michigan Department of Health Laboratory has continued the use of VDRL and has made it a permanent policy to use this test.

2. The records of the Michigan Rapid Treatment Center have been abstracted onto file cards which are permanently available at the office of the Director of Adult Health and TB of the Michigan State Health Department.

3. The Committee recognized the need for physician education in venereal disease and it was reported that some work along this line is being done in Detroit. However, there is still no formal venereal disease program at the Wayne State University School of Medicine.

4. The Chair reported that a letter had been sent to the U. S. Public Health Service on January 4, 1962 stating that the Michigan State Medical Society urges the U. S. Public Health Service to reconsider its abandonment of screening surveys and requests that it consider supplying funds to the various states for this purpose. The letter was answered by Wm. J. Brown, M.D., Chief, Venereal Disease Branch of the Department of Health, Education, and Welfare on February 2, 1962, enclosing a copy of the Task Force Report on Syphilis Control in the United States which report summarizes the priorities to be followed by the USPHS. In brief, the letter advocated that all laboratories doing serologic tests for syphilis report positive tests to the local health department.

5. The Michigan Hospital Association had been contacted on January 4, 1962, urging that Association to reinstitute its requirement for a routine admission STS by hospitals for accreditation. Subsequently, the Committee adopted a motion that the MSMS Council recommend that the Michigan Department of Health take steps to insure that serological tests for syphilis be done on all hospital admissions. This recommendation of the Committee was disapproved by The Council, MSMS in July of this year, with the recommendation that more information be supplied to justify the action requested and some provision made for deviation. The Committee will follow through on The Council recommendation.

6. It was reported that cases of primary and secondary syphilis were on the increase throughout the world. It was felt that perhaps some reason for this might be the lack of interest in this disease and the decreased use of penicillin in treatment of other diseases.

7. It was also reported that the Attorney General of the State of Michigan had recently ruled that a public health officer, acting in his capacity as public health officer, can diagnose and treat a minor for venereal disease, or suspected venereal disease, without consent of the parent, and this does not constitute assault.

8. It was reported that regulations were now in effect in Michigan regarding the reporting of positive serology tests and that they are working. However, there is still opposition to reporting a test as implying the diagnosis of a disease; the pathologists feel there is a violation of their relationship with other physicians; that there is a reasonable area for stigmatization of a person inasmuch as papers and records are not always kept confidential and destroyed; and, that the pathologists in Michigan feel such reporting should be done but in a different way.

The Committee adopted a motion to take no action.

Under the heading of "new business," the Committee reviewed and placed on its agenda for future discussion and action:

1. A possible recommendation to the Michigan Delegates to the American Medical Association that a resolution be introduced into the AMA House of Delegates, advocating that all State Medical Societies establish active committees on venereal disease control. The Committee will ascertain if this action is necessary.

2. The Committee is studying the recommended schedule for the treatment of syphilis, gonorrhea, chancroid, lymphogranuloma, venereum and granuloma inguinale, as recommended by the Michigan Department of Health.

3. The Committee will obtain up-to-date information on the advisability of recommending that the Michigan Department of Health take steps to insure that serological tests for syphilis be done on all hospital admissions.

THE REFERENCE COMMITTEE on Reports of Standing Committees recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

O. B. McGillicuddy, M.D., *Chairman*

This committee had no formal meetings but on occasion members of the Committee have given advice and encouragement.

The Auxiliary officers have served splendidly and these officers and the working members are hereby congratulated.

THE REFERENCE COMMITTEE on Reports of Standing Committees, H. W. Harris, M.D., Chairman, recommended approval of this report.

THE HOUSE adopted the report of the Reference Committee.

The following committees did not meet this year and therefore do not have Annual Reports:

Blood Banks Committee
Tuberculosis Control Committee

17. Reports of House of Delegates Committees

JOINT COMMITTEE ON MEDICINE AND OSTEOPATHY

John J. Coury, M.D., *Chairman*

1. The Committee of the House of Delegates to study Osteopathy and the Liaison Committee of The Council felt that the committees should be combined for efficiency purposes, and this was done

2. In March, 1964, this Joint Committee and members of The Council met with the AMA Committee on Medicine and Osteopathy. Much worthwhile information was derived from this meeting for your Committee's future deliberations.

3. The Joint Committee made every effort to implement the 1963 House of Delegates recommendation: "That the MSMS affirm a policy of professional respect and cooperation with the Michigan Association of Osteopathic Physicians and Surgeons, in those areas of common responsibility and common interest where such cooperation can be of benefit to the people of Michigan."

In carrying out this recommendation, the MSMS Committee was hindered by two developments: (1) The litigation in the Peoples Community Hospitals in the downriver area, and (2) difficulty in carrying out liaison while litigation is in progress.

4. The MSMS Joint Committee on Medicine and Osteopathy reviewed the minutes of the meetings of the MSMS House of Delegates Committee to Study Relationship Between Doctors of Medicine and Osteopathy and some of its proposed recommendations to the 1964 House of Delegates.

5. The Joint Committee has reviewed the established policies of the MSMS House of Delegates and from these has derived the following statement which reviews and clarifies MSMS policy: "That it shall not be considered unethical for members of the MSMS to associate professionally and on a voluntary basis with Doctors of Osteopathy who base their practice on the same scientific and ethical principles as Doctors of Medicine.

"That it shall be considered ethical for osteopathic physicians to be admitted to a hospital staff providing:

(a) The component medical society approves.

(b) Doctors of Osteopathy apply on an individual basis and meet the same requirements as Doctors of Medi-

cine for admission, and if accepted, adhere to the rules and regulations of that hospital staff and of the Joint Commission on Accreditation for Hospitals.

(c) The hospital staff is integrated (not dual or separate) in accordance with the policy laid down by the Joint Commission."

6. The Joint Committee on Medicine and Osteopathy submits the following three proposed recommendations for the consideration of the House of Delegates:

(a) That MSMS continue to work toward the ultimate goal of establishing in Michigan a single Medical Practice Act.

(b) That MSMS approve of individual osteopaths being invited to attend MSMS postgraduate educational activities, invitations to be extended to those osteopaths meeting the criteria previously adopted by the House.

(c) That component societies be encouraged to invite local practicing osteopaths to attend educational activities at the local and regional level.

7. That consideration be given to the following additional proposals, which have been discussed by the MSMS Committee:

(a) That the Michigan State Board of Registration in Medicine be asked to review its decision of denying license to former osteopaths who have been licensed as M.D.s by the State of California.

(b) That the MSMS Committee be authorized to explore all avenues of action which might lead to a plan enabling osteopaths to obtain M.D. licensure in Michigan.

(c) That this Joint Committee be continued in 1965 and the members of the Joint Committee be from the House of Delegates, The Council, and members-at-large—to be appointed by the President. It is also recommnded that the function of the Liaison Committee be assumed by the Joint Committee on Medicine and Osteopathy.

The MSMS Committee recognized that the establishment of such programs would involve many difficulties and would be a long-range project. However, the Committee believed that it is very important that a step be taken in this direction.

THE REFERENCE COMMITTEE on Reports of Special Committees, B. E. Brush, M.D., Chairman, reported its recommendations to the House in Executive Session. The Reference Committee recommended approval of Items 1 through 6 of the Annual Report.

THE HOUSE adopted this portion of the Reference Committee Report.

On Item 7, the Reference Committee recommended approval.

The House did not adopt this portion of the report, but amended 7-b as follows: "7-b. That the MSMS Committee be authorized to explore all avenues of action which might lead to a plan enabling osteopaths licensed to practice in Michigan as of July 1, 1964, to obtain M.D. licensure in Michigan."

The House adopted the report as a whole, as amended, with commendation to the Joint Committee on Medicine and Osteopathy.

CENTENNIAL ADVISORY COMMITTEE

L. F. Hayes, M.D., *Chairman*

This House of Delegates committee was charged with making a study and recommendations on how best the House of Delegates might observe the 100th Annual Session of the Michigan State Medical Society in 1965.

The Committee considered the possibility of calling a special session of the House of Delegates to observe the Centennial. It was felt that expenditure of extra funds for this purpose was not warranted. It was also felt that since the House is the legislative body of MSMS, its primary concern is the conduct of its business. Therefore, within the structure of its regular agenda, the following observances are recommended:

(1) during the first meeting of the House on Sunday evening, addresses by three outstanding religious leaders (Protestant, Jewish, and Roman Catholic);

(2) during the second meeting of the House on Monday morning, an address by a national medical figure, possibly a medical educator;

(3) on Monday evening, a special dinner honoring past Speakers of the House; and

(4) on Tuesday noon, concurrent with the meeting of Michigan Medical Service, an address by a nationally recognized expert in the socio-economic sphere.

In connection with the Tuesday noon observance, and because the creation of Michigan Medical Service itself was one of the outstanding historical events in a century of Michigan medicine, the Michigan Medical Service is encouraged to include in its corporate meeting reflection upon the history of Michigan medicine.

The Committee also recommends that a special badge be issued to all those attending the Centennial Meeting of the House of Delegates, and that any special speakers who address the House in connection with the Centennial observance receive either a commemorative plaque or medal.

Finally, the Committee recommends that an advisory committee be continued to coordinate the House of Delegates with the MSMS Council's Centennial Committee.

THE REFERENCE COMMITTEE on Special Committees, Brock E. Brush, M.D., Chairman, recognized the important function of this centennial year, and hoped the Centennial Advisory Committee would continue its excellent efforts to make this an outstanding year in Michigan medicine. The Reference Committee hoped that all recommendations in the annual report will be developed and enlarged so that a maximum observance of this historical year will be celebrated.

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE ON EMERGENCY CARE IN HOSPITALS

J. R. Pedden, M.D., *Chairman*

The Committee on Emergency Care in Hospitals held its first meeting on May 8, 1964, at MSMS headquarters, Lansing, Michigan. Present were: Don Marshall, M.D., Kalamazoo; R. M. Stow, M.D., East Lansing; John R. Pedden, M.D., Grand Rapids; Ralph T. Wills, of the MSMS staff.

The committee reviewed and discussed the 1963 report of the Ad Hoc Committee on Emergency Care in Hospitals. This report was considered to be an excellent and informative foundation for further recommendations. We commend the preceding committees for their contributions to this continuing study. The committee's recommendations are:

1. That organized medicine recognize and anticipate changing needs of the public relative to medical care in the emergency room. That the public needs vary widely from the small rural areas to the large metropolitan areas. That it is desirable that each area should devise appropriate means within the wide areas of guidance established by the MSMS to meet this problem. That the MSMS incorporate principles of the official recommendations from the AMA as summarized on Pages 31 to 34, of the AMA report, "Report on Physician-Hospital Relations, June 1964." That MSMS recognize the gradual evolution of function of the emergency room in our hospitals, whereby the emergency department has now become an initial source of medical care and refuge for people during times of acute illness when they are unable to obtain medical advice and help from their private physician, and that MSMS urge constituent county society members to meet this challenge to provide improved and enlarged emergency room care under the guidance and control of private medicine by utilizing one of several methods to be suggested.

2. That MSMS accept the premise that it is impracticable to originate regulatory rules generally applicable to all areas

and communities to prevent abuse and over-utilization of emergency departments. Therefore, patients applying at the emergency department of hospitals for help should receive necessary INITIAL medical assistance. Emergency cases must of course be cared for, and all others must be at least screened. Patients sent to the emergency room for the convenience of a referring physician, and patients appearing in order to utilize insurance or gain some economic advantage, should be sent to a private physician whenever possible. Efforts to regulate this situation should be attempted by education of the physicians, education of the public, economic pressure on the patient by charging higher fees for this type of service or encouraging a deductible insurance coverage. The committee recognizes the current trend of great pressure being exerted by non-medical groups to make medical care and hospital insurance a fringe benefit, and that deductible insurance will be actively resisted. The committee recommends that the public be educated to realize that the demand for medical care at unusual hours can only be justified when it is a true emergency and that even then, the use of the emergency department of the hospitals would be more expensive for them than to be seen by their private physician. We urge recognition that the problem of over-utilization is one of the most serious problems confronting the emergency department. Because of the practical difficulty in adequate staffing of the emergency departments in many hospitals, we suggest that physicians in all areas of this state be prepared to solve this problem by one of the following general measures:

(A) Service provided by intern and resident staff under supervision of private hospital staff members.
(B) Voluntary assigned rotation of hospital staff members.
(C) Lansing Plan, whereby provision in the emergency department of initial care only is supplied by private practicing physicians who limit themselves to this field only, are always readily available and charge for their services by fee for service.
(D) House staff members who are paid additional salaries for service rendered in the emergency department on off hours.

The committee further suggests that each local hospital situation be solved individually.

3. The committee recommends that any service rendered by a licensed practicing physician in the emergency room of a hospital should be on a fee-for-service basis in compliance with the principles of the Michigan State Medical Society, that hospitals be discouraged from providing salaried medical personnel to render emergency care service and that physicians maintain the responsibility for administering care in the emergency department.

4. That physicians continue to recognize that the care in the emergency department is one of the most sensitive areas of public relations between the physician, hospital and public.

THE REFERENCE COMMITTEE on Emergency Medical Service, J. C. Danforth, M.D., Chaiman, reviewed the annual report of the House of Delegates Committee on Emergency Care in Hospitals. It commended the Committee for a precise and thoughtful report on a subject that demands the serious consideration of every member of the Michigan State Medical Society with the following comments and recommendation.

"They have emphasized the evolution of the emergency room in its struggle to meet the changing needs of the public. The growth of its function has been paralleled by problems of its efficiency that vary from rural to metropolitan service. With the general recognition of available facilities it has gradually emerged as a haven for initial care when other sources become unavailable. The responsibility for this rests squarely on the shoulders of the practicing physician, who must realize that a breach in availability will unquestionably nurture the hospital emergency room practice of medicine.

"Inasmuch as these facilities are already in widespread use for non-emergent problems, a method of screening must be found to manage those who present themselves as a convenience to a referring or unavailable physician, those who would avail themselves of insurance utilization, those who have established no relationship with a private physician. It is recommended that the public be educated as to the true purpose of the function of an emergency room, and that services rendered are usually of greater cost than in the office of the private physician.

"Four suggestions of staffing are proposed. Basically all provide the direct supervision of a licensed physician who would function on a fee-for-service principle.

"It is emphasized that this area of care is one of the most sensitive in public relations between the patient, the physican, and hospital.

"The Reference Committee had the benefit of the commentary of many interested guests. It was emphasized that a basic definition of emergency care be established, as well as a criteria of what constitutes an adequate emergency facility. It appears impractical for every hospital institution to provide the means of definitive treatment to all types of emergency states. Due to costs involving equipment and personnel, the prospect of regional facilities divided into categories was discussed. Available aid ranging from critical to non-critical problems could be designated and made known to all police, fire and ambulance personnel.

"It is recommended by this Reference Committee that the present House of Delegates Committee continue in its study and evaluate the practicality of establishing a State Commission comprised of knowledgeable physicians, for the purpose of designating standards for a uniform pattern of facilities throughout the State."

THE HOUSE adopted the report of the Reference Committee.

COMMITTEE TO STUDY PROCEDURE OF HOUSE OF DELEGATES

H. A. Furlong, M.D., *Chairman*

This Committee was appointed by the Speaker of the House of Delegates pursuant to the passage of Resolution No. 75 by the 1963 House of Delegates. It met in East Lansing on May 27, 1964 to consider ways and means of operating the House more effectively and, after careful study, made certain recommendations to the Speaker so that he might implement those he deemed worthy.

Speaker Lightbody relayed the Committee's recommendations to the appropriate officers of Michigan Medical Service and they agreed to condense the MMS Corporation meeting so that the MSMS House of Delegates would have additional time available for its deliberations.

The Committee also initiated a request that resolutions be handled more expeditiously and for the greater advantage of all of the Delegates by their submission prior to the convening of the House, with introduction at the first session of the House. The method of introduction of resolutions was also hopefully improved.

A complete schedule of order of business for the 1964 House of Delegates was developed by the Committee for the consideration of the Speaker and the assistance of the MSMS staff in preparing the Delegates' Notebook, including the recommendation for installation of the President of MSMS during the State Society Dinner Dance, in keeping with recommendations from the Committee of Past Presidents for improving this ceremony.

Finally, the Committee recommends to the House of Delegates that, through appropriate action, it authorize the Speaker to create a similar Committee to function between the 1964 and 1965 sessions of the House to continue to seek improvements in House procedure.

THE REFERENCE COMMITTEE on Miscellaneous Business, F. H. Power, M.D., Chairman, noted the Annual Report contained many suggestions for simplifying and expediting the work of the House of Delegates. The Study Committee was commended and the Reference Committee recommended approval of the report.

THE HOUSE adopted the report of the Reference Committee.

AD HOC COMMITTEE TO STUDY SECTION REPRESENTATION IN THE HOUSE OF DELEGATES

H. F. Falls, M.D., *Chairman*

This Committee was created by the Speaker of the House to implement Resolution No. 62 of the 1963 House of Delegates, for the purpose of studying in depth the structure of the Sections of the Michigan State Medical Society and to make recommendations with respect to election of delegates to represent MSMS Sections.

The Committee was also referred Resolution No. 4 of 1963, regarding change of name of a present MSMS Section.

The Committee conducted two meetings during the year and authorized its Chairman to circularize all major specialty organizations in the State of Michigan on two occasions to solicit their views with respect to whether they felt that their Sections were presently properly constituted, whether they would support a Section of MSMS if they did not presently have one, and whether they desired to elect a delegate to the MSMS House of Delegates purely on the basis of Section representation.

Further, the Committee obtained information from the State of New York, where the medical society is presently unique among those in the nation in that it has Section representation as does the American Medical Association.

A heavy response was obtained to both the Committee's questionnaires to the specialty organizations, and in excess of eighty per cent of those responding were in favor of Section representation. It was apparent from the responses that there can be anticipated formal requests in 1964 to the House of Delegates for the creation of two or three new Sections, and it is apparent that one or two of the existing Sections feel that they should be subdivided.

The Committee feels after careful study, in order that the State Society and the specialty organizations may mutually benefit from a more meaningful Section system by making possible an official and knowledgeable voice where problems affecting respective specialties face the House, and to create a greater unity and interest in MSMS within the framework of the Sections, that the following three specific recommendations are necessary:

1. The Committee recommends that steps be taken by the 1964 House of Delegates to amend the Constitution and Bylaws of MSMS to permit presently authorized and established Sections of MSMS to each elect one Delegate and one Alternate Delegate to serve for two-year terms, commencing with the 1965 session of the House;

2. The Committee recommends that any request from a specialty organization to establish or to change the composition of a Section of MSMS be directed to the House of Delegates from the specialty organization or Section through the usual channels for action under the provisions of Section 8 (h) of Chapter 9 of the MSMS Bylaws. The Committee further recommends that the House of Delegates authorize advising all specialty organizations and/or Sections of this methodology; and

3. The Committee, after thorough discussion of the present composition of the Michigan State Medical Society, concludes that Section 8 (h) of Chapter 9 of the MSMS Bylaws merits intensive study by the MSMS Committee on Constitution and Bylaws and recommends that the Constitution and Bylaws Committee be directed by the House to spell out in detail the criterion by which Section 8 (h) of Chapter 9 of the MSMS Bylaws will be implemented in the future. However, in connection with Resolution No. 4 of 1963, and to coincide with the Michigan Society of Psychiatry and Neurology, the Committee recommends that the House of Delegates now change the name of the present, "Nervous and Mental" Section to "Psychiatry and Neurology" Section.

The Committee, in making the foregoing three recommendations, has discharged its responsibility in connection with Resolution No. 62 of 1963 and requests that it be dissolved.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, recommended, with reference to recommendation No. 1 of the ad hoc Committee, that Chapter IX, Section 2 of the Bylaws be altered to read in line 2 as follows:

"The officers of this Society, the members of The Council, and one delegate from each authorized section shall be ex officio members of the House of Delegates," and so forth.

This is the section that has to do with delegates-at-large and ex officio members. It simply adds to that category a delegate from each authorized section.

In Chapter IX, Section 8 (h), at the end of the section, the second line at the top of page 12, following the word "officers," the period should be deleted and the words "and delegates-at-large" should be added.

In explanation, this action thus permits each established section to elect one delegate-at-large, who will have the right of the floor to speak but who will not have a vote.

The ad hoc Committee suggested in recommendation No. 2 an intensive study by the regular Committee on Constitution and Bylaws of Section 8 (h) of Chapter IX, and your Reference Committee agreed that this should be done, and recommends approval by the House.

As a third item, the ad hoc Committee recommended that the House change the name of the present Nervous and Mental Section to the Psychiatry and Neurology Section. Your Reference Committee approves this recommendation and suggests that you endorse it.

THE HOUSE adopted the report of the Reference Committee at its next meeting, after it had been laid over according to the Bylaws.

STANDING COMMITTEE ON CONSTITUTION AND BYLAWS

H. M. Golden, M.D., *Chairman*

The Committee met in the MSMS Headquarters on June 19, 1964 and after careful deliberation recommends the following actions to the 1964 MSMS House of Delegates:

(1) that the House amend Section 1, Article 8 of the MSMS Constitution to add the words "non-resident members" after the words "retired members." (This amendment, as required by the Constitution, has been laid over since the 1963 session of the House);

(2) that the House amend the Bylaws of MSMS, Section 4, Chapter 5, to insert the phrase, following the comma which follows the word "Society" in line 5, "or if such component county society exacts no dues." This will enable the State Society to reduce dues to physicians during their first year of practice if their county society exacts no dues;

(3) that the House amend the Bylaws of MSMS, Section 10, Chapter 9, after the period which follows the word "District" in line 8 thereof, to insert "If, by reason of death or resignation, a vacancy in the office of Councilor occurs at any time other than during an Annual Session, each component county society in the District in which such vacancy occurs shall be promptly notified in writing by the Secretary of the Society. Thereupon the seated Delegates of such Councilor District may caucus and if a majority of the seated delegates from such Councilor District shall submit a nomination to the Council to fill such vacancy, the Council shall appoint such nominee to serve as Councilor of such District until the House of Delegates, at its next Annual Session, shall have elected a successor to fill the unexpired term." Section 10 shall then proceed with the present final sentence thereof. This will enable the filling of a vacancy which might occur at a time other than during the Annual Session of the Society;

(4) that the House amend the Bylaws of MSMS, Section 4, Chapter 9, after the word "seat" in line 11, to add a comma and the words "for the duration of the emergency" and another comma. This will clarify what is meant by the term "emergency" in regard to the seating of Alternate Delegates;

(5) that the House amend Section 1, Chapter 11 of the Bylaws of MSMS to delete present sub-section (b) and substitute therefore a new sub-section (b) to read as follows: "(b) The Public Health Committee shall consist of a Chairman, the State Health Commissioner or his authorized representatives, public health officers, and members to be appoint-

ed by the President. The duties of this committee shall be to collect, analyze and distribute information on preventive medicine, and to advise medical and other groups or individuals concerning problems in preventive medicine and public health." Further, that the House amend the Bylaws of MSMS, Section 1, Chapter II, to add after new subsection (b) above a new sub-section (c) to read as follows: "(c) The following scientific committees, and such other committees as may, from time to time, be appointed to study and develop programs dealing with specific diseases, shall be Standing Committees of the Society and their scope, purposes and composition shall be determined by The Council:

Committee on Cardiac Disease Control
Committee on Maternal Health
Committee on Venereal Disease Control
Committee on Tuberculosis Control
Committee on Cancer Control
Committee on Occupational Medicine
Committee on Mental Health
Committee on Child Welfare
Committee on Geriatrics*
Committee on Rural Medical Service
Committee on Blood Banks
Committee on Highway Accident Prevention
Committee on Diabetes Control
Committee on Iodized Salt."

The Committee has also considered or received for consideration a number of other matters including the report of the Utilization Committee, which will be analyzed in the light of uniform judicature provisions presently under development by the American Medical Association for recommendation to constituant state societies, reports of the deliberations of the Ad Hoc Committee to Study Section Representation in the House of Delegates, and interim reports of studies concerning the alignment of county medical societies and councilor districts. These matters were accepted by the committee for information only, there being further information under development in connection with the first matter, and the second two being subjects outside of the specific jurisdiction of the committee.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., chairman, reported the following recommendations on the Annual Report of the Standing Committee on Constitution and Bylaws:

Item 1: That the House amend Section 1, Article 8 of the Michigan State Medical Society Constitution to add the words "non-resident members" after the words "retired members." (This amendment, as required by the Constitution, has laid over since the 1963 Session of the House.)

The Reference Committee recommended approval of this amendment.

THE HOUSE adopted the report of the Reference Committee.

THE REFERENCE COMMITTEE continued its report as follows:

"Item 2: That the House amend the Bylaws of the Michigan State Medical Society, Chapter 5, Section 4, to insert the phrase, following the comma which follows the word "Society" in line 5, "or if such component county society exacts no dues." This will enable the State Society to reduce dues to physicians during their first year of practice if their county society exacts no dues.

"The Reference Committee recommends this change but recognizes that it must be held over to a following meeting.

"Item 3: That the House amend the Bylaws of the Michigan State Medical Society, Chapter 9, Section 10, after the period which follows the word "District" in line 8 thereof, to insert "If, by reason of death or resignation, a vacancy in the office of Councilor occurs at any time other than during an Annual Session, each component county society in the District in which such vacancy occurs shall be promptly notified in writing by the Secretary of the Society. Thereupon the seated delegates of such Councilor District may caucus, and if a majority of the seated delegates from such Councilor District shall submit a nomination to The Council to fill such vacancy The Council shall appoint such nominee to serve as Councilor of such District until the House of Delegates, at its next Annual Session, shall have elected a successor to fill the unexpired term."

"Section 10 shall then proceed with the present final sentence thereof. This will enable the filling of a vacancy which might occur at a time other than during the Annual Session of the Society.

"The existing Bylaws allow for the replacement of a Councilor only during the particular meeting we are attending now. If the Councilor is inconsiderate enough to leave us at any other time of the year, there is no mechanism to replace him. Therefore, the Reference Committee recommends this change but recognizes that it must lie over to a following meeting.

"Item 4: That the House amend the Bylaws of the Michigan State Medical Society, Chapter 9, Section 4, after the word 'seat' in line 11, to add a comma and the words 'for the duration of the emergency' and another comma. This will clarify what is meant by the term 'emergency' in regard to the seating of alternate delegates. It will in effect mean that if a regularly seated delegate is called away at the beginning of the session, and an alternate is seated in his place, upon return of the regularly seated delegate he may then resume his seat and the alternate goes back to the alternate status. The Reference Committee recommends this change but recognizes that it must lie over to a following meeting.

"Item 5: The Reference Committee added the stipulation that not less than 75 per cent of the Committee on Public Health is to be selected from physicians in private practice, in accord with substitute Resolution No. 28 of 1963, and changed the name of the Committee on Tuberculosis Control to the Committee on Respiratory Diseases.

"With this amendment, Item 5 now reads:

" 'That the House amend Section 1, Chapter 11 of the Bylaws of the Michigan State Medical Society to delete present subsection (b) and substitute therefor a new subsection (b) to read as follows:

" '1 (b) The Public Health Committee shall consist of a Chairman, the State Health Commissioner or his authorized representatives, public health officers, and members to be appointed by the President. Not less than 75 per cent of the Committee is to be selected from physicians in private practice.

" 'The duties of this Committee shall be to collect, analyze and distribute information on preventive medicine, and to advise medical and other groups or individuals concerning problems in preventive medicine and public health. Further, that the House amend the Bylaws of the Michigan State Medical Society, Section 1, Chapter 11, to add after new subsection (b) above, a new subsection (c) to read as follows: '(c) The following scientific committees, and such other committees as may from time to time be appointed to study and develop programs dealing with specific diseases, shall be Standing Committees of the Society, and their scope, purposes and composition shall be detemined by The Council.

Committee on Cardiac Disease Control
Committee on Maternal Health
Committee on Venereal Disease Control
Committee on Respiratory Diseases
Committee on Cancer Control
Committee on Occupational Medicine
Committee on Mental Health
Committee on Child Welfare
Committee on Aging
Committee on Rural Medical Service
Committee on Blood Banks
Committee on Highway Accident Prevention
Committee on Diabetes Control
Committee on Iodized Salt' "

*New sub-section (c) above lists the "Committee on Geriatrics." The Committee on Constitution and Bylaws here recommends that the House amend the designation of this committee henceforth to be "Committee on Aging";

Finally, that present sub-section (c) of Section 1, Chapter 11 of the Bylaws which deals with the Committee on Public Relations be redesignated as sub-section (d), and all following sub-sections be redesignated appropriately.

Finally, that present subsection (c) of Section 1, Chapter 11 of the Bylaws which deals with the Committee on Public Relations be re-designated as subsection (d), and all following subsections be re-designated appropriately.

The Reference Committee recommends these changes, but recognizes that they must lie over to a following meeting.

THE HOUSE adopted, at a subsequent meeting of the House, the report of the Reference Committee, in accordance with the Bylaws.

RESOLUTIONS

RESOLUTION 1

To Establish Annual Recognition of Michigan's Outstanding Physician

Introduced by D. Bonta Hiscoe, M.D., and Henry E. Malcolm, M.D., Ingham

Whereas, recognition of a physician as Michigan's Foremost Family Physician was discontinued by the Michigan State Medical Society House of Delegates, and

Whereas, the public relations value of this recognition of one of its members has been diminished by discontinuing the honor, and

Whereas, the Distinguished Service Awards do not necessarily replace the recognition previously accorded Michigan's Foremost Family Physician, therefore be it

RESOLVED: That the Michigan State Medical Society House of Delegates reinstate an annual recognition of a member of the profession, who is not necessarily a family physician, nor one advanced in years, and that this form of recognition be known as Michigan's Outstanding Physician, and be it further

RESOLVED: That consideration be given to the physician's civic accomplishments as well as his professional accomplishments.

THE REFERENCE COMMITTEE on Reports of Special Committees, B. E. Brush, M.D., chairman, recommended approval of the resolution and that the Speaker annually appoint an ad hoc committee to make the selection from nominations submitted by component medical societies.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 2

Area-wide Hospital Planning

Introduced by F. P. Rhoades, M.D., Wayne

Whereas, the Michigan State Medical Society recognizes the need for area-wide hospital planning; and

Whereas, the House of Delegates of the American Medical Association has already adopted the principle of physician participation and leadership in voluntary local hospital planning and vigorous opposition to the principle of compulsory area-wide hospital planning; therefore be it

RESOLVED, That the Michigan State Medical Society House of Delegates declares its support of voluntary area-wide hospital planning by representatives, on an equal basis, from the hospital associations, the medical societies, and the community; and be it further

RESOLVED, That the medical representatives be selected by the Michigan State Medical Society and include physicians from the area concerned; and be it further

RESOLVED, That copies of this resolution be forwarded to the Michigan Hospital Association and the Greater Detroit Area Hospital Council, Inc.

THE REFERENCE COMMITTEE on Miscellaneous Business, F. H. Power, M.D., chairman, approved the resolution with the following amendments to enhance implementation of the resolution by The Council: the first Resolved to be deleted, and the following Resolved be substituted therefor,

Resolved: that the MSMS House of Delegates declares its support of the principle of voluntary area-wide hospital planning by a committee having adequate representation of practicing physicians, the hospital associations, and the communities.

In the second Resolved, the Reference Committee inserted the word "practicing" between the words "include" and "physicians."

The Reference Committee then recommended approval of the resolution as amended.

THE HOUSE amended the Reference Committee Report by the addition of the words, "the county medical societies" after the word "associations" in the substitute for the first Resolved. Also, the House amended the report to substitute "physicians in private practice" for the words "practicing physicians" in both the first and second Resolved.

The House adopted the Reference Committee report as amended by the House.

RESOLUTION 3

Chiefs of Staff and Services in Hospitals

Introduced by F. P. Rhoades, M.D., Wayne

Whereas, the members of the medical profession have need of democratic principles in the operation of the hospital medical staff; and

Whereas, these democratic principles should include the right of the active medical staff:

1. To elect its own officers;
2. To review and revoke the action of such officers, medical staff committees and medical staff members;
3. To nominate and/or elect the chiefs of departments and divisions of the medical staff of the hospital for submission to the board of trustees for their approval; therefore be it

RESOLVED, That boards of trustees of all private non-governmental hospitals in Michigan be urged to consult with and obtain the approval of the medical staff by democratic nomination and/or election of all chiefs of staff and of services prior to their appointment; and be it further

RESOLVED, That a copy of this resolution be sent to the boards of trustees of all private, non-governmental hospitals in Michigan.

THE REFERENCE COMMITTEE on Resolutions, H. F. Falls, M.D., chairman, recommended approval, enthusiastically endorsing the sentiment expressed, though recognizing the resolution lacks implementation.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 4

Dissemination of Information to Woman's Auxiliary to SAMA

Introduced by Edward E. Elder, Jr., M.D., Oakland

Whereas, the advantages of medical practice in the State of Michigan are known to all of us, and

Whereas, many graduates of our medical schools and residency training programs leave Michigan to practice in other states, therefore be it

RESOLVED, That this House of Delegates and the Council of MSMS disseminate information about the advantages of practice in Michigan, particularly smaller towns, to the wives of senior medical students, interns, and residents through the Woman's Auxiliary to the Student American Medical Association, and that this be done at the county as well as the state level.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., chairman, recommended approval of the resolution and urged creation of formal liaison committees between local SAMA chapters and component medical societies and urged similar liaison committees between the auxiliaries of the SAMA chapters and component medical societies.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 5

Remuneration for Councilors and Presidents and Secretaries of County Medical Societies

Introduced by Richard R. Galpin, M.D., Oakland

Whereas, the scientific and medical socio-economic activities of the Michigan State Medical Society and the component county medical societies are becoming ever more complex and time-consuming, and

Whereas, the Michigan State Medical Society and the component county medical societies have been well and ably served by their elected representatives, and

Whereas, such services are extremely important to the individual members of the Michigan State Medical Society and to that body as a whole, and

Whereas, such services, by their demanding nature, may place a real financial handicap on those who serve by reducing the hours the physician concerned has to devote to his practice, and

Whereas, this will reduce the income of said physicians directly in proportion to the amount of service they render to the above societies, and

Whereas, it is particularly important to insure that the societies continue to be served by representatives of high qualification, therefore be it

RESOLVED, That the present committee of The Council which is studying the question of remuneration to officers of the Michigan State Medical Society be requested to enlarge this study to include Councilors, presidents of county medical societies, and secretaries of county medical societies and be it further

RESOLVED: That said committee be requested to evaluate this problem in realistic terms as to the value of the time being given by said elected representatives, and be it further

RESOLVED: That the monies required for such a program be obtained by a suitable increase in dues to all active members of the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Resolutions, H. F. Falls, M.D., chairman, recommended approval of the resolution with the following amendments:

In the first Resolved, the words "and delegates to the AMA" were added after the word "councilors". The sentence, "Presidents of county medical societies and secretaries of county medical societies" was deleted.

The last Resolved was deleted.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 6

MSMS Section on Orthopedic Surgery

Introduced by H. W. Harris, M.D., Ingham

Whereas, the practice of orthopedic surgery has become widespread throughout the State of Michigan, and

Whereas, almost all cities in the State have practitioners in this specialty, and

Whereas, the teachings of orthopedic surgery not only to orthopedists but to all physicians should be continued and improved, and

Whereas, this can be best accomplished in meetings such as that of the Michigan State Medical Society, therefore be it

RESOLVED: That a Section on Orthopedic Surgery be established in the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., chairman, recommended that no action be taken on this resolution, but that it be referred to the Standing Committee on Constitution and Bylaws which is already authorized to study criteria for section membership and other details which should be spelled out before new sections are created.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 7

Improvement in Medical Aid to Aged Program (Kerr-Mills)

Introduced by A. Hazen Price, M.D., Wayne

Whereas, the Social Security Programs that have been and are being urged by the present administration in Washington could lead to a compulsory health care program for everyone in the United States with domination of physicians and hospitals by the federal government, and

Whereas, the present Kerr-Mills law which is successfully operative in a large number of our states, including Michigan, insures a minimum of interference by the Federal Government, and

Whereas, there are many fine features in the present law, yet, many improvements could be made so it would be more acceptable and available to more of our needy elderly citizens who need assistance when serious and prolonged illness develop and yet are not on public welfare roles, and

Whereas, many states have seen fit to make certain worthwhile changes which have not only broadened the benefits but have also greatly decreased the cost of operation, therefore be it

RESOLVED: That this House of Delegates request the Committee of the Michigan State Medical Society to take whatever steps are necessary to initiate the introduction of appropriate bills into our State Legislature which would modify and improve our present Medical Care to Aged Program, and be it further

RESOLVED: That the Geriatrics Committee of the Michigan State Medical Society, the Michigan Commission on Aging and the Michigan Health Council, all be asked to make appropriate recommendations.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., chairman, recommended approval of this resolution with the addition of a third Resolved: "That each county medical society in the State of Michigan be encouraged to implement more fully the Kerr-Mills Act for the needy aging at local levels."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 8

Advance Submission of House of Delegates Resolutions

Introduced by Wm. G. Gamble, Jr., M.D., Bay-Arenac-Iosco

Whereas, there has been a great increase in the number of decisions the House of Delegates must make, and

Whereas, there is insufficient time during the House of Delegates sessions to reach considered opinions and many matters are referred to The Council, and

Whereas, the members of the House would be better prepared if advised in advance on the matters of business, be it therefore

RESOLVED: That resolutions to be considered by the House of Delegates shall be submitted thirty days before the House convenes and transmitted to the Delegates, and be it further

RESOLVED: No resolutions submitted after this deadline will be considered by the House of Delegates unless approved by a two-thirds vote of the members present.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., chairman, recommended disapproval of this resolution. Although the committee was in sympathy with the intent, it believed the resolution would tend to complicate and obstruct the business of the Society.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 9

Establishment of a Formal Coordinated Program of Active Counseling in Medicine and Allied Sciences

Introduced by W. Clarence Beets, M.D., Kent

Whereas, the need for more physicians and ancillary personnel has become increasingly apparent in recent years, and

Whereas, the number of young people interested in the health field and the potential graduates are not sufficient to fill the need, and

Whereas, the bargaining for these ancillary services has contributed to higher wages, and

Whereas, this in turn has contributed considerably to the higher cost of medical care, and

Whereas, the Federal Government has in the past and more recently appropriated considerable monies for aid in training in the allied health services, therefore be it

RESOLVED: That the Michigan State Medical Society establish a formal coordinated program of active counseling in medicine and allied sciences:

(a) To be recommended and expedited at the county level,
(b) With active physician participation in our local high schools and colleges.

THE REFERENCE COMMITTEE on Miscellaneous Business, F. H. Power, M.D., chairman, recommended adoption of the following:

Substitute Resolution 9

"Whereas, the need for more physicians and ancillary personnel has become increasingly apparent in recent years, and

"Whereas, the number of young people interested in the health field and the potential graduates are not sufficient to fill the need, and

"Whereas, the Federal Government has in the past and more recently appropriated considerable monies for aid in training in the allied health services; therefore, be it

"RESOLVED: That the Michigan State Medical Society establish a committee to assemble all pertinent information concerning careers in medicine and paramedical fields, for distribution to the county medical societies, encouraging them to initiate an appropriate counseling program in these fields on a local level."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 10

Better Control of Public Health Officers

Introduced by Robert J. Fles, M.D., Muskegon

Whereas, county public health officers are currently responsible to no one but the board of supervisors of their respective counties, and

Whereas, many county public health officers engage in the private practice of medicine while in the full employ of their respective county governmental units, and

Whereas, a few county public health officers maintain absolutely no communication with their component societies or the State Department of Health, and

Whereas, the State Department of Health does contribute substantially to the annual remuneration of these various county health officers, and their offices; therefore be it

RESOLVED: That the Legal Affairs Committee of MSMS be instructed to begin an investigation of this problem in conjunction with the State Department of Health to see if any steps can be taken to insure better co-operation with, and control of, county public health officers.

THE REFERENCE COMMITTEE on Hygiene and Public Health, E. C. Baumgarten, M.D., chairman, considered Resolutions 10 and 17 together and recommended the adoption of the following:

Substitute for Resolutions 10 and 17

"Whereas, public health is the art and science concerned with community health problems, rather than the specific diagnosis and treatment of the individual, except as defined by law, and

"Whereas, trends in modern society have increased the complexity of providing personal and public health services, and

"Whereas, the public is always better served by patterns of efficient services which complement one another, and

"Whereas, society unity will be enhanced by a positive program to develop efficient coordinated health services; therefore, be it

"RESOLVED: That The Council of the Michigan State Medical Society be directed to establish a special committee with equitable representation of members of the Michigan State Medical Society in private practice and representatives of the Public Health Services to develop recommendations for such a program."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 11

Establishment of MSMS Judicial System

Introduced by Gregory P. Moore, M.D., Wexford-Missaukee

Whereas, there is increased awareness of the need for the medical profession to maintain and, indeed, strengthen its high ethical principles and procedures, and

Whereas, the House of Delegates has made certain recommendations re utilization investigation and disciplinary action, and

Whereas, The Council has been carrying out a thorough review of the MSMS ethics and mediation procedures with the assistance of the AMA, and

Whereas, The Council, in its efforts to implement House of Delegates recommendations, is hindered by the existing Bylaws, and the overall complexities of changes in this area of concern, and

Whereas, the President-Elect, with the approval of The Council, recommends the establishment of a modern MSMS judicial system, therefore be it

RESOLVED: That this House of Delegates approve the principle of a Judicial Board and authorize the establishment of a Judicial Commission, appointed by the President of MSMS, to prepare recommendations providing for a permanment Judicial Board and System to become effective following the 1965 Annual Session of MSMS.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, unanimously endorsed the resolution with enthusiasm, having amended the Resolved to read:

"RESOLVED: That this House of Delegates approve the principle of a Judicial Board and authorize the establishment of a Judicial Commission appointed by the President of the Michigan State Medical Society, to study criteria of medical care and frequency of use, and to prepare recommendations providing for a permanent Judicial Board and system, to become effective immediately following the 1965 Annual Session of the Michigan State Medical Society."

THE HOUSE adopted the report of the Reference Committee.

THE REFERENCE COMMITTEE, subsequently, in a Supplemental Report, proposed a Constitutional amendment, a new Article 11, which read as follows:

"Article 11. Judicial Board. Section 1—Composition, Powers and Duties.

"The Judicial Board shall be the body having general jurisdiction in matters relating to professional ethics, grievances, discipline of members, utilization of health insurance benefits, and professional conduct generally. It shall consist of members to be elected by the voting members of the Society. The number of members, their terms of office, the time and manner of their election, and the specific powers and duties of the Board shall be as prescribed by the Bylaws."

THE HOUSE laid this over until the 1965 Session of the House, as provided in the Constitution and Bylaws.

RESOLUTION 12

Relationship of Physicians

Introduced by K. T. McGunegle, M.D., Sanilac

Whereas, in some areas of the state, due to distance and unavailability of specialists in each field of the practice of medicine, it is necessary that many people be treated by physicians not specifically trained in the appropriate specialty field, and

Whereas, this results many times in situations which cause friction between physician and physician, and physician and patient, therefore be it

RESOLVED: That the MSMS through an appropriate committee, re-examine the problem of the relationship be-

tween the attending physician and the consulting surgeon or appropriate specialist from the standpoint of

1. Their relative responsibility to the patient.
2. The relative value of the work done by each physician.

THE REFERENCE COMMITTEE on Resolutions, H. F. Falls, M.D., Chairman, recommended the resolution be not adopted for these reasons: (1) the problem is one of the intimate relationship between the physician, the consultant and the patient, and (2) is not within the purview of present mechanics of the MSMS.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 13

Football Supervision

Introduced by K. T. McGunegle, M.D., Sanilac

Whereas, there are thousands of growing children participating in competitive interscholastic football, and

Whereas, our medical profession professes to be the adviser and guardian of the health of the people of Michigan, therefore be it

RESOLVED: That the MSMS urge its constituent societies, through committees or some other suitable means, to see that each football game (varsity at least) have a physician attending such games.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., Chairman, recommended deletion of the Resolved portion, and substituting therefor, the following:

Resolved: That The Council of the MSMS establish a Committee on the Medical Aspects of Organized Athletics; and be it further

Resolved: That each component society urge its members to provide medical service for organized athletic programs.

As amended, the Reference Committee recommended the resolution be adopted.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 14

Amendment to MSMS Bylaws, Chapter 11, Section 1 (b), Tuberculosis Control Committee to Committee on Respiratory Diseases

Introduced by L. A. Drolett, M.D., Ingham

Whereas, the problem of tuberculosis control is not as acute as in the past, and

Whereas, there is a great need in the area of control of other respiratory diseases, and

Whereas, air pollution has become a more serious problem, therefore be it

RESOLVED: That Chapter 11, Section 1 (b) be amended to change the name of the Tuberculosis Control Committee to the Committee on Respiratory Diseases, and be it further

RESOLVED: That the proper reference committee take action to expedite this matter at this session of the House of Delegates, if possible.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, recommended approval of the resolution with the deletion of the last Resolved.

THE HOUSE adopted the report of the Reference Committee after laying this item over until the following meeting in accordance with the Bylaws.

RESOLUTION 15

Proposed Increase in AMA Dues

Introduced by Donald N. Sweeny, Jr., M.D., Wayne

Whereas, the House of Delegates of the American Medical Association has under consideration a proposal to increase the American Medical Association dues each year until they total $100 in 1967, and

Whereas, the purpose of this proposed increase in dues is to provide better communications with the members and to assist the local societies in their programs, and

Whereas, the most effective means of communications with the membership in any democratic organization is at the local level, and

Whereas, the American Medical Association has always believed that local needs can best be met by local action and that national assistance should be provided only on the basis of demonstrated need, and

Whereas, the proposed increase in American Medical Association dues would deter the component medical societies from increasing their dues and expanding their activities and programs, therefore be it

RESOLVED: That the proposed increase in dues to the American Medical Association be not approved, and be it further

RESOLVED: That the American Medical Association encourage and assist the component medical societies in developing better communications with their members, their respective state societies, the American Medical Association, and the public.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., Chairman, recommended approval of the resolution with the addition of the following sentence to the last Resolved: "If additional funds are necessary to improve these communications with the state and county societies, an adjustment of dues should be at the local rather than the national level."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 16

Indigent Physicians and Their Wives

Introduced by David I. Sugar, M.D., Wayne

Whereas, there are physicians who are or have been members of the Michigan State Medical Society and wives of these physicians who are unable because of illness, old age, or other difficulties to support themselves or their families, and

Whereas, neither social security or any other funds are available to assist needy physicians and their wives, and

Whereas, the first responsibility of the Michigan State Medical Society should be to the members who support it, and

Whereas, the Michigan State Medical Society has allocated $20 or more per member for many years to public relations programs, therefore be it

RESOLVED: That The Council of the Michigan State Medical Society be instructed to consider the development of a fund to help needy physician-members and their wives and that this program be financed out of public relations monies, the amount to be allocated not to exceed $2.00 per member annually.

THE REFERENCE COMMITTEE on Ways and Means, J. R. Pedden, M.D., Chairman, recommended approval of the resolution amended as follows:

"Whereas, there are physicians who are or who have been members of the Michigan State Medical Society and wives and dependents of these physicians who are unable because of illness, old age, or other difficulties to support themselves or their families, and

"Whereas, neither adequate OASI nor any other funds are as yet available to assist needy physicians and their wives and dependents, and

"Whereas, the Michigan State Medical Society has a responsibility to the members who support it; therefore, be it

"RESOLVED: That The Council be instructed to continue its study of a plan of financial assistance to needy physicians and their dependents and to report such plan to the next meeting of the Michigan State Medical Society House of Delegates in 1965."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 17

Definition of Public Health

Introduced by F. P. Rhoades, M.D., Wayne

Whereas, the 1962 American Medical Association House of Delegates defined Public Health as follows: "Public Health is the art and science of *maintaining,* protecting and improving the health of the people through organized community efforts. It includes those arrangements whereby the community provides medical services for *special groups* of persons and is concerned with prevention or control of *disease,* with persons requiring hospitalization to protect the community and with the medically indigent"; and

Whereas, the Michigan State Medical Society's County Societies Committee in a 1964 report to The Council of the Michigan State Medical Society considered this American Medical Association definition as too broad in that it could be construed as including possible total control of the practice of medicine; and

Whereas, the 1964 American Medical Association House of Delegates referred the matter to the American Medical Association Board of Trustees; therefore be it

RESOLVED: That the House of Delegates, Michigan State Medical Society, adopt the following definition of public health: "Public Health is the art and science concerned with community health problems rather than the specific diagnosis and treatment of the individual and that the services of departments of public health should be limited to:

1. Vital statistics
2. Public health education
3. Environmental sanitation
4. Prevention and control of communicable diseases
5. Industrial health hazards
6. Maintenance of health laboratories, if private facilities are not available
7. The medical aspects of community-wide disasters in cooperation with other appropriate governmental agencies (Civil Defense)
8. Standards for maternal and child health

and be it further

RESOLVED: That the delegates from Michigan State Medical Society to the American Medical Association be asked to submit a resolution embodying the above definition at the next session of the American Medical Association House of Delegates.

THE REFERENCE COMMITTEE on Hygiene & Public Health, E. C. Baumgarten, M.D., Chairman, considered Resolutions 10 and 17 together. For Reference Committee and House action, see Resolution 10.

RESOLUTION 18

Michigan Hospital Service and the Physician

Introduced by V. V. Bass, M.D., Saginaw

Whereas, the Michigan Blue Cross Program involves a contract between Michigan Hospital Service and individual and group subscribers, and

Whereas, the Michigan Blue Cross Program involves an agreement between Michigan Hospital Service and specific hospitals in Michigan and their administrative boards, and

Whereas, there is neither agreement with nor consultation with Michigan Blue Cross, the Michigan Hospital Service, and the individual physician, and

Whereas, any agreement between Michigan Hospital Service and the hospitals in Michigan, either on an individual basis or collectively, does not involve or imply agreement by the physician, and

Whereas, present practices of the Michigan Hospital Service imply facts which are contrary to the policies as presented in the contract between Michigan Hospital Service and the patient, and

Whereas, these practices require that the hospital involve the physician in the completion of forms based on misinformation and upon matters which do not involve the physician, therefore be it

RESOLVED: That the physicians in Michigan advise the Michigan Hospital Service and any hospital administrators involved in this practice that the physician is opposed to being a party thereof, and be it further

RESOLVED: That the physicians in Michigan see no need to take any action other than refusal, individually and/or collectively, to participate in such administrative programs as the Michigan Hospital Service should develop, and be it further

RESOLVED: That the delivery of this Resolution to the Michigan Hospital Service is to be interpreted as adequate notice that the physicians in Michigan will no longer, as of the date of adoption of this Resolution and its delivery to the Michigan Hospital Service, comply with the requests of the Michigan Hospital Service and the participating hospitals, in any administrative way, to be involved with the Michigan Hospital Service demands, directly or indirectly.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, recommended disapproval of this resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 19

Private Health Insurance for the Aging

Introduced by D. B. Hiscoe, M.D., Ingham

This resolution has been passed by the Ingham County Medical Society and forwarded to the Michigan State Medical Society for action.

Whereas, doctors of medicine should be and are concerned about the social and economic problems of medical care, and

Whereas, The physicians of the Michigan State Medical Society are anxious to help develop a system of more adequate care for all, preserving at the same time the fundamental principles of free choice of physician, private practice of medicine, high quality of medical care, and

Whereas, we all support the Kerr-Mills Act as a fundamental step in this direction, and

Whereas, we also feel that as further government assistance is deemed necessary for certain individuals, especially in the older age groups, the medical profession should be on record in support of a positive program consistent with these goals, therefore, be it

RESOLVED, that the Michigan State Medical Society support a program that allows

(1) the federal government to subsidize the elderly individual of limited means in his private purchase of health insurance in the open market, and

(2) the federal government to establish certain minimum standards of financial responsibility and benefits to be provided, such standards to be met by the insurance companies involved in such a program, and be it further

RESOLVED, that this resolution be forwarded to the American Medical Association for action.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., Chairman, recommended disapproval of this resolution.

The House did not adopt the report of the Reference Committee.

THE HOUSE adopted Resolution 19 as introduced.

RESOLUTION 20

Medical Review and Arbitration Committees

Introduced by Laurence Segar, M.D., Wayne

Whereas, the problem of evaluating prepaid medical services has been given careful study by the Ad Hoc Committee to Study Proposed Utilization Committee of the Michigan State Medical Society; and

Whereas, this Ad Hoc Committee has recommended:

(1) That each county medical society establish a Review and Arbitration Committee to review facts submitted and take appropriate corrective action when indicated;

(2) That the Michigan State Medical Society establish a

Review and Arbitration Committee to act as an appeal body and, where indicated, with authority to recommend solutions that may be prescribed by component socicty committees; and

Whereas, The Council of the Michigan State Medical Society has referred the report to the Committee on Constitution and Bylaws for implementation; therefore be it

RESOLVED, that the House of Delegates of the Michigan State Medical Society approve the recommendations of the Ad Hoc Committee to study Proposed Utilization Committee; and be it further

RESOLVED, that the Committee on Constitution and Bylaws be instructed to prepare any necessary changes in the Bylaws of the Michigan State Medical Society to implement the recommendations of the Ad Hoc Committee and to present the report of the Committee on Constitution and Bylaws to this session of the House of Delegates for action.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, recommended that this resolution be referred to the Judicial Commission for advice.

THE HOUSE re-referred the Reference Committee report on Resolution 20 to the Reference Committee on Constitution and Bylaws, along with Substitute Resolution 20, which read as follows:

Substitute Resolution 20—J. B. Blodgett, M.D., Wayne.

Whereas, this House has approved Resolution No. 11 and implementation of this Resolution will require Bylaws changes, therefore be it

RESOLVED: That the Committee on Constitution and Bylaws be instructed to prepare any necessary changes in the Bylaws of MSMS to implement Resolution No. 11 and that these Bylaw changes be presented to the House at this session.

THE REFERENCE COMMITTEE on Constitution and Bylaws, in its Supplemental Report, recommended that no action be taken on Substitute Resolution 20, since the spirit of the resolution can be implemented under existing Bylaws. (No action was taken on Resolution 20.)

In addition, the Reference Committee recommended that the Judicial Commission, as authorized in Resolution 11, be activated immediately and serve as a functioning review and advisory committee in addition to its function as a study commission.

THE HOUSE adopted the Supplemental Report of the Reference Committee.

RESOLUTION 21

Merit Rating

Introduced by Ralph R. Cooper, M.D., Wayne

Whereas, the present policy of Michigan Medical Service to charge the same rate to everyone (community rating) has resulted in loss of subscribers and income, in rate increases and public criticism, and

Whereas, merit rating would reimburse Michigan Medical Service for actual costs plus a subsidy for the low-income groups and subscribers over 65, and

Whereas, such an equitable distribution of costs would encourage enrollment and maintain the fiscal soundness of Michigan Medical Service, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society endorse in principle the adoption of merit rating by Michigan Medical Service.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, recommended approval of the Resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 22

Evaluation of Prepaid Medical Services

Introduced by Herbert Devine, M.D., Wayne

Whereas, it is essential for Michigan State Medical Society to have specific information as to the frequency of use of any prepaid medical services; and

Whereas, such information is necessary to enable the medical profession to maintain and improve the quality of medical care, and

Whereas, only physicians are competent to judge the propriety of medical services, therefore be it

RESOLVED: That The Council of the Michigan State Medical Socicty be instructed to appoint, not later than January 1, 1965, a fact-finding committee of physicians, without punitive powers, to evaluate the prepaid medical services rendered in Michigan, and be it further

RESOLVED: That the source of information submitted to this committee be unidentified as to physician or patient.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, recommended approval of this resolution with the two Resolved portions amended as follows:

"RESOLVED: That The Council of the MSMS be instructed to appoint, not later than January 1, 1965, a fact-finding committee of physicians, without punitive powers, to evaluate utilization of prepaid medical services rendered in Michigan, and be it further,

"RESOLVED: That the sources of information submitted to this committee not be identified as to physician or patient."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 23

Michigan Diabetes Detection Program

Introduced by Frank S. Perkin, M.D., Wayne

Whereas, diabetes mellitus is rapidly increasing in significance as a medical problem with a potential incidence of over 30 per cent of the population, and

Whereas, diabetes mellitus is a metabolic disorder with no recognized practices of prevention or control and is primarily a responsibility of the private practice of medicine; and

Whereas, the Michigan Diabetes Detection Program has screened over 20 per cent of all cases in the United States in a state with less than 3 per cent of the total population, therefore be it

RESOLVED: That the Michigan State Medical Society encourage and urge all its members to support and cooperate with the Michigan Diabctes Detection Program which is sponsored by the Michigan State Medical Society and the Michigan Diabctes Association with co-sponsorship and representation on its Advisory Committee of the Michigan Department of Health, the Michigan Society of Pathologists, the Detroit Department of Health, and the Wayne County Health Department, and be it further

RESOLVED: That the Michigan State Medical Society recognizes and appreciates the cooperation of the State, County, and City Health Departments in this program, and be it further

RESOLVED: That copies of this resolution be forwarded to each of the sponsoring groups of the Michigan Diabetes Detection Program and to every county medical society in Michigan.

THE REFERENCE COMMITTEE on Resolutions, H. F. Falls, M.D., Chairman, recommended approval of the resolution amended to read as follows:

"Whereas, diabetes mellitus is of increasing significance as a medical problem, with a potential incidence of over 30 per cent of the population, and

"Whereas, diabetes mellitus is a metabolic disorder and its detection and treatment are primarily responsibilities of the private practice of medicine, and

"Whereas, to date the Michigan Diabetes Detection Program has screened over 20 per cent of all the diabetes cases screened in the United States, and this in a State with less

than 3 per cent of the population of this country; therefore, be it

"RESOLVED: That the Michigan State Medical Society encourage and urge all of its members to support and cooperate with the Michigan Diabetes Detection Program, which was sponsored by the Michigan State Medical Society, the Michigan Diabetes Association, the Michigan Department of Health and the Michigan Society of Pathologists, and co-sponsored by local health departments and county medical societies. It is urged that this successful sponsorship be resumed; and be it further

"RESOLVED: That the Michigan State Medical Society recognizes and appreciates the cooperation of the state, county and city health departments in this program; and be it further

"RESOLVED: That copies of this resolution be forwarded to each of the sponsoring groups of the Michigan Diabetes Detection Program and to every county medical society in Michigan."

THE HOUSE adopted the report of the Reference Committee except that the House added the word "past" before "cooperation" in the second Resolved.

RESOLUTION 24

Section on Allergy and Applied Immunology in Michigan State Medical Society

Introduced by L. Dell Henry, M.D., Washtenaw

Whereas, the Michigan Allergy Society was founded in 1936, and

Whereas, the Michigan Allergy Society has a membership of approximately 100 medical physicians, and

Whereas, the Science of Allergy and Applied Immunology is an integral part of the teaching of medicine both at the undergraduate and graduate levels, and

Whereas, the membership of the Michigan Allergy Society participates actively in the teaching program at the University of Michigan Medical School and the Wayne State Medical School, and in postgraduate clinics throughout the State of Michigan, and

Whereas, the allergists, who are members of the Michigan Allergy Society are also active in national and international allergy societies, therefore be it

RESOLVED: That a Section on Allergy and Applied Immunology be authorized within the structure of the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Constitution and Bylaws, C. J. Tupper, M.D., Chairman, recommended no action on this resolution, but that it be referred to the Standing Committee on Constitution and Bylaws which is already authorized to study criteria for section membership and other details which should be spelled out before new sections are created.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 25

Preservation of the Patient-Physician Privilege of Confidential Communication

Introduced by Louis E. Heideman, M.D., Wayne

Whereas, the Wayne County Circuit Court has proposed an amendment to the General Court Rules of Michigan, to-wit: "Rule 311.2 (2) Commencement of suit for personal injuries by any party shall constitute a waiver of the patient-physician privilege, the attorney-client privilege relating to the physical or mental condition of the person seeking damages, or any other privilege relating to his physical or mental condition," and

Whereas, in the confidential nature of the patient-physician relationship it is essential that the patient disclose to his physician many of his innermost thoughts and actions of a most secret nature, and

Whereas, this confidential communication of the patient to his physician has, heretofore, been protected by law, and

Whereas, the broad language of the proposed Rule 311.2 (2) would abolish the privilege in the case of every individual involved in personal injury litigation by the mere act of his commencing suit, and

Whereas, this broad language of the proposed amendment would have a pronounced tendency to reduce the likelihood of full disclosure by the patient to his physician of important history which might be essential to adequate treatment of the patient, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society is vigorously opposed to the adoption of Rule 311.2 (2) of the General Court Rules of Michigan as being inimical to the best interests of patient care; and be it further

RESOLVED: That a copy of this Resolution be sent to every member of the Supreme Court of Michigan, to every Circuit Judge in Michigan, to the Michigan State Bar Association and to the Detroit Bar Association.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., Chairman, recommended approval of the resolution with the following changes:

In the first Resolved, substitute for the word "inimical" the word "detrimental" so that this portion would read: "RESOLVED: That the House of Delegates of the Michigan State Medical Society is vigorously opposed to the adoption of Rule 311.2 (2) of the General Court Rules of Michigan as being detrimental to the best interests of patient care."

Delete the second Resolved in its entirety and substitute the following:

"RESOLVED: That this resolution be referred to The Council of the Michigan State Medical Society for early study, expeditious disposition and prompt implementation through proper existing liaison mechanisms with the Michigan State Bar Association."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 26

Urging Participation in MDPAC and AMPAC

Introduced by Hugh T. Caumartin, M.D., Saginaw

Whereas, the Michigan Doctors Political Action Committee (MDPAC) and the American Medical Political Action Committee (AMPAC) are organized by doctors for political education and direct candidate support, and

Whereas, medicine is confronted now and will be confronted in the future by powerful political forces seeking passage of federal legislation dangerous to the basic principles underlying our American system of medical care, and

Whereas, such organizations as MDPAC and AMPAC are absolutely essential to combat political malpractice under any program of government-controlled medicine, therefore be it

RESOLVED: That we Delegates here assembled give our endorsement and encouragement to the Michigan Doctors Political Action Committee and the American Medical Political Action Committee, and we strongly recommend and urge that every Michigan doctor of medicine become a dues-paying member of the Michigan Doctors Political Action Committee and AMPAC.

THE REFERENCE COMMITTEE on Resolutions, H. F. Falls, M.D., Chairman, recommended approval of the resolution amended to delete the words "political malpractice under" in the last whereas, and deleting the word "dues-paying" in the Resolved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 27

M.D.-D.O. Relations

Introduced by Robert M. Leitch, M.D., Branch

Whereas, osteopaths are licensed by the State of Michigan to practice medicine and surgery; and

Whereas, hospitals which are supported by public funds are required by law to accept D.O.s to the medical staffs of said hospitals, and

Whereas, the presence of two medical disciplines on the

same medical staff results in confusion for both the administration of the hospitals and the medical staffs, and

Whereas, the practice of medicine and surgery could best be performed by one discipline of medical philosophy, therefore be it

RESOLVED: That the Michigan State Medical Society recommend to the State Legislature that all D.O.s practicing scientific medicine be given M.D. degrees; and that from the date of such action forward no new D.O.s be licensed to practice in Michigan.

THE REFERENCE COMMITTEE on Reports of Special Committees, B. E. Brush, M.D., Chairman, recommended no action on the Resolution since the intent is covered in the Annual Report of the Committee on Medicine and Osteopathy.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 28

Commendation of John M. Sheldon, M.D., for Outstanding Service to MSMS in Postgraduate Education

Introduced by Harold F. Falls, M.D., Washtenaw

Whereas, Doctor John M. Sheldon has served successfully in the capacity of chairman of the MSMS Postgraduate Medical Education Committee for a number of years, and

Whereas, in such capacity he and his committee has evolved a postgraduate educational program second to none in this country, and

Whereas, in such capacity he and his committee have created an excellent rapport and spirt of cooperation between Wayne State University School of Medicine and the University of Michigan Medical School faculties in postgraduate education service in this state, therefore be it

RESOLVED: That the House of Delegates of MSMS express its appreciation to Doctor John M. Sheldon for a job extremely well done, and be it further

RESOLVED: That a copy of this resolution be forwarded to Doctor John M. Sheldon.

THE REFERENCE COMMITTEE on Resolutions, H. F. Falls, M.D., Chairman, recommended approval of this Resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 29

Mental Health

Introduced by Benjamin Jeffries, M.D., Wayne

Whereas, the purpose and intent of Public Act 236, 1963, (following the adoption of the Constitution) was that the Director of the Department of Mental Health was to be appointed by and responsible directly to the Governor. The director was required to be a medical man trained in psychiatry and the policy-making and the director-hiring Mental Health Commission was abolished and replaced by a Mental Health Advisory Council. This Act clearly fixed responsibility and accountability for this major function of government; and

Whereas, the passage of Public Act 54, 1963, the Community Mental Health Services Act, provides Michigan with a tested vehicle for more effective coordination of mental health programs and services of all agencies involved at the local level, while bringing responsibility and participation closer to the people; and

Whereas, forty-four per cent of all state employees paid from the General Fund are employed by the Department of Mental Health and over half of all hospital beds are occupied by mental patients; and

Whereas, we believe that to submerge the department of government which carries the banner of visibility, respectability and responsibility for the mentally ill would be regression and reaction, not progress; and

Whereas, we believe that the Department of Mental Health as presently constituted is large enough and complex enough for any one department of government, therefore be it

RESOLVED: That the Michigan State Medical Society recommends that the Department of Mental Health be designated as one of the principal departments of state government, as directed by the Constitution revision of 1963, and that after the principal reorganization has been affected, any shifts of mental health responsibilities currently parts of other agencies be made on a functional basis by executive order.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., Chairman, recommended this Resolution be referred to The Council of MSMS without prejudice, for its continuing study and recommendations at an appropriate time to the Executive office of the State of Michigan.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 30

Tetanus Immunization

Introduced by Homer Howes, M.D., Wayne

Whereas, tetanus is always a potential complication of injury; and

Whereas, the production and maintenance of active immunization against this infection is very successful; and

Whereas, the average person needs to be reminded of this immunization; therefore be it

RESOLVED: The Michigan State Medical Society, in an effort to have as many persons as possible in Michigan immunized against tetanus, recommend to the Secretary of State that a place on each driver's license be arranged so that the licensee may record the status of his tetanus immunization; and be it further

RESOLVED: That the Michigan State Medical Society also recommend to the Commissioner of the Department of Health that he prepare a memorandum which would routinely be sent with each driver's license issued, and which would explain and remind each licensee of the importance and technique of active tetanus immunization.

THE REFERENCE COMMITTEE on Hygiene and Public Health, E. C. Baumgarten, M.D., Chairman, recommended approval of the Resolution, amending the last Resolved to read:

"RESOLVED: That the MSMS also recommend to the State Health Commissioner that he prepare a memorandum which would routinely be sent with each driver's license issued, and which would explain and remind each licensee of the importance of procedure and timing of active tetanus immunization."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 31

Subacute Medical Facilities

Introduced by William J. Yott, M.D., Wayne

Whereas, there is an urgent necessity for medical facilities in the State of Michigan for the care of recuperative patients, and

Whereas, usage of rehabilitation facilities and hospital beds have increased due to the prepayment insurance and population growth, and

Whereas, the cost of acute hospital care is of necessity much greater than it would be in this type of intermediate or subacute facility, and

Whereas, it would make many more beds in the acute institutions available and decrease the bed shortage; therefore be it

RESOLVED: That the Michigan State Medical Society request the appropriate committee of Michigan State Medical Society to establish standards and procedures for classification and licensure of medical facilities for the care of subacute illnesses.

THE REFERENCE COMMITTEE on Miscellaneous Business, F. H. Power, M.D., Chairman, amended the Resolution by adding, in the Resolved after the word "licensure," the words "by the State," and recommended approval of the Resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 32

Malpractice Coverage

Introduced by Alexander Blain, III, M.D., Wayne

Whereas, some insurance agencies have refused to renew the malpractice insurance for a number of physicians unless some other type of insurance are included as a package deal; and

Whereas, these physicians are finding it difficult to obtain coverage elsewhere, therefore be it

RESOLVED: That the Council of the Michigan State Medical Society at its meeting September 24, 1964, call this problem immediately to the attention of the Insurance Commissioner of the State of Michigan.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., Chairman, amended the Resolution by deleting the Resolved and substituting therefor:

"RESOLVED: That these allegations be referred to The Council of the MSMS for investigation and documentation, and that at an early appropriate time these matters be brought to the attention of the Insurance Commission of the State of Michigan." It then recommended approval of the Resolution as amended.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 33

Michigan Relative Value Scale Conversion Factor

Introduced by A. R. VandenBerg, M.D., Kent

Whereas, Michigan State Medical Society has placed itself on record favoring Michigan Relative Value Scale in principle, and

Whereas, continued delays have occurred implementing this relative scale, and

Whereas, the Relative Value Scale is truly relative and equitable only when the conversion factor of $5.00 is used as was the case in developing the scale, therefore be it

RESOLVED: That the Michigan State Medical Society urge implementation of Michigan Relative Value Scale and be it further

RESOLVED: That the unit value for the average income subscriber be established at not less than $5.00 for future contracts.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, recommended no action on this Resolution since the matter was being studied by another Committee.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 34

Michigan State Board of Registration in Medicine

Introduced by Floyd Levagood, M.D., Wayne

Whereas, the medical profession of Michigan is vitally concerned with violations of the Medical Practices Act of the State of Michigan, and

Whereas, it is impossible for the State Board of Registration in Medicine, because of an inadequate budget, to completely fulfill its responsibilities, and

Whereas, the medical physicians of the State of Michigan pay, through registration, re-registration and examination fees, more than an adequate amount of money for the proper and effective enforcement of the Medical Practices Act by the State Board of Registration in Medicine, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society request the State of Michigan to allocate sufficient funds to the Board of Registration in Medicine to enable adequate enforcement of the Medical Practices Act of the State of Michigan, and be it further

RESOLVED: That copies of this resolution be furnished to the Governor of Michigan and sent to all members of the State Legislature.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., Chairman, recommended approval of the Resolution with the following changes: Add "has been reported" after "it" in the second Whereas; substitute for the first Resolved "Resolved: That this House of Delegates request the State Board of Registration in Medicine to inform The Council (1) whether it has adequate enforcement power under the present Medical Practice Act and, if not, in what respect it should be strengthened, (2) whether it has an adequate budget to administer an effective program of enforcement and, if not, what additional funds are required and the purposes for which they will be used," and (3) deletion of the second Resolved.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 35

Medical Schools

Introduced by Jack Rom, M.D., Wayne

Whereas, the quality of medical education is of the greatest possible significance to every segment of our society, and

Whereas, it is the responsibility of the American Medical Association through its Council on Medical Education to establish standards for the accreditation of medical schools, and

Whereas, the state and county components of the American Medical Association share this responsibiilty at the local level, and

Whereas, the effective conduct of any medical school depends to a marked degree upon liaison with and mutual understanding of the local medical practitioners, therefore be it

RESOLVED: That when any new medical school, especially if tax supported, is to be established or any basic or fundamental change is to be made in any existing school, it is in the best interests of all concerned for the governing bodies of such medical schools to seek the advice and cooperation of the state and county components of the American Medical Association in the establishment of medical educational policies, and be it further

RESOLVED: That copies of this resolution shall be sent to all members of the governing boards or regents of the universities in Michigan who have medical schools.

THE REFERENCE COMMITTEE on Miscellaneous Business, F. H. Power, M.D., Chairman, recommended disapproval of the Resolution.

THE HOUSE did not adopt the recommendation of the Reference Committee.

The House adopted the Resolution as introduced.

RESOLUTION 36

Relationships between Doctors of Medicine and Doctors of Osteopathy

Introduced by W. L. Brosius, M.D., Wayne

Whereas, the Board of Commissioners of the Joint Commission on Accreditation of Hospitals, Bulletin No. 25, states: (1) "Only doctors of medicine or doctors of osteopathy shall practice in hospitals listed by the American Hospital Association. (2) "If doctors of osteopathy are practicing in the hospital, then, under the requirements for listing, the overall supervision of clinical work must be under a doctor of medicine (as chief of staff and chief of department, if departmentalized)", and

Whereas, the Michigan State Plan for Hospital and Medical Facilities construction for 1961-1962 - Supplement (Hill-Burton) states; Section V, Paragraph 3: "The State Agency does not believe the difference in composition of staff is sufficient to justify programming of separate facilities for patients of medical and osteopathic physicians in communities which could not otherwise justify the existence of two separate hospitals, recognizing that any decision with respect to physician staff privileges is the prerogative of the local community," and

Whereas, the University of Michigan Study on Hospitals and Medical Economics (the McNerney Report) points out methods by which health care of the people of Michigan could be improved by better coordination between doctors of medicine and doctors of osteopathy, and

Whereas, the Governor's Commission on Prepaid Hospital and Medical Care Plans (the Bowles' Report) recommends that the appropriate state medical and osteopathic societies promptly take all measures necessary to permit hospitals to consider joint osteopathic and medical staffs, and

Whereas, separate hospitals for doctors of medicine and doctors of osteopathy are an uneconomical addition to the overall cost of medical care to the public, and

Whereas, there are now hospitals in Michigan with doctors of medicine and doctors of osteopathy on their staffs with approval of their respective county medical societies, therefore be it

RESOLVED: That it shall not be considered of itself unethical to admit doctors of osteopathy who base their practice on the same scientific and ethical principles as doctors of medicine to staff membership in hospitals in Michigan accredited by the Joint Commission on the Accreditation of Hospitals of the American Medical Association in the same manner and subject to the same regulations as doctors of medicine when the county medical society in which the hospital is located gives its approval.

THE REFERENCE COMMITTEE on Reports of Special Committees, B. E. Brush, M.D., Chairman, recommended no action on this Resolution since the matter is covered in the Annual Report of the Committee on Medicine and Osteopathy.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 37

Relationships between Doctors of Medicine and Doctors of Osteopathy

Introduced by W. L. Brosius, M.D., Wayne

Whereas, it is the duty of Doctors of Medicine to work for the improvement of health care, and

Whereas, Doctors of Osteopathy are working toward the same goal, and

Whereas, health care will be improved by better relations between Doctors of Medicine and Doctors of Osteopathy, and

Whereas, the Michigan State Medical Society House of Delegates in 1962 resolved "that it shall not be considered unethical for members of the Michigan State Medical Society to associate professionally, and on a voluntary basis, with Doctors of Osteopathy who base their practice on the same scientific and ethical principles as Doctors of Medicine, therefore be it

RESOLVED: That Doctors of Osteopathy be invited to attend scientific assemblies and programs for educational purposes sponsored by the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Reports of Special Committees, B. E. Brush, M.D., Chairman, recommended no action on this Resolution since the matter had been covered in the Annual Report of the Committee on Medicine and Osteopathy.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 38

Need for Separation of Sections in Michigan Relative Value Study

Introduced by B. C. Payne, M.D., Washtenaw

Whereas, the overhead cost of the practice of medicine varies between specialties, and

Whereas, alterations in conversion factors affect different physicians to varying degrees in relation to their net income, and

Whereas, the unit value of Michigan Relative Value Study is only relative within a type of practice, therefore be it

RESOLVED: That the relative values for each section (that is, Surgery, Medicine, Radiology, Pathology) be considered separately.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, amended the Resolution substituting in the third Whereas the words "similar fields" for the words "a type" and in the Resolved adding after "that" the words "the monetary unit value and" and also removing the period and adding "and independently" and recommended adoption of the amended resolution.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 39

Medical Legal Insurance

Introduced by Milton R. Weed, M.D., Wayne

Whereas, medical-legal insurance is becoming more difficult to obtain and in some instances is not available, and

Whereas, the judiciary often award damages of such magnitude as to pauperize an uninsured defendant, therefore be it

RESOLVED: That the appropriate committee of the Michigan State Medical Society investigate immediately the problem of malpractice insurance in Michigan to include availability of insurance by commercial carriers, rates of premiums, frequency of malpractice cases, feasibility and desirability of the establishment of a malpractice insurance company by Michigan State Medical Society, its legal implications and possible rate structure, and other matters of similar nature essential to determine if Michigan State Medical Society should underwrite malpractice insurance for its members, and be it further

RESOLVED: That said committee shall report its findings to the next session of the Michigan State Medical Society House of Delegates, and be it further

RESOLVED: That the Michigan Delegates to the American Medical Association be requested to initiate a similar study of malpractice insurance.

THE REFERENCE COMMITTEE on Resolutions, H. F. Falls, M.D., Chairman, recommended approval of the resolution with minor amendments to the first Resolved so it reads as follows:

"RESOLVED: That an appropriate committee of the MSMS investigate immediately the problem of malpractice insurance in Michigan, to include: (1) availability of insurance of commercial carriers; (2) rates of premiums; (3) frequency of malpractice suits, and (4) feasibility and desirability of the establishment of a malpractice insurance company by MSMS. This Committee should also study the legal implications, possible rate structure, and other matters of a similar nature essential to determine if MSMS should underwrite malpractice insurance for its members."

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 40

Implementation of Michigan Relative Value Study

Introduced by George S. Fisher, M.D., Wayne

Whereas, Michigan Medical Service has requested a change from community to merit rating, and

Whereas, Michigan Relative Value Study has not yet been implemented by Michigan Medical Service, therefore be it

RESOLVED: That Michigan Medical Service incorporate utilization of Michigan Relative Value Study in its new contracts using adequate conversion factors.

THE REFERENCE COMMITTEE on Medical Service and Prepayment Insurance, J. B. Blodgett, M.D., Chairman, recommended no action on this Resolution since the matter is still in Committee deliberation.

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 41

Norman A. Welch, M.D.

Introduced by Donald N. Sweeny, Jr., M.D., Wayne

Whereas, Norman A. Welch, M.D., President of the American Medical Association, represented the finest prototype of personal medical practitioner, teacher and statesman, and

Whereas, Norman A. Welch, M.D., unstintingly devoted many years of his life at all levels of organized medicine and private practice to promulgate the ideals of our profession and to urge a singleness of purpose and action for the benefit of the public and the profession, and

Whereas, by the tragic and untimely death on September 3, 1964, of Norman A. Welch, M.D., this nation, the world, and particularly the medical profession, has been deprived of his patient, tactful and kindly energies on its behalf, therefore be it

RESOLVED: That the Michigan State Medical Society humbly express to the family of Norman A. Welch, M.D., its deepest sympathies in this hour of bereavement, and be it further

RESOLVED: That the Michigan State Medical Society pledge to carry out his program dedicated to the unity of all segments of our profession toward a better health care for the public, and be it further

RESOLVED: That this Resolution be forwarded in proper form to the Board of Trustees of the American Medical Association, there to be spread on its minutes.

THE HOUSE suspended the rules and considered the Resolution sitting as a Committee of the whole.

The House adopted the Resolution and observed a moment of silence.

RESOLUTION 42

County Society Student Loan Activity

Introduced by Gerhard H. Bauer, M.D., Washtenaw

Whereas, the recruitment of medical students is the continuing responsibility of every physician, and

Whereas, many students, in the face of increasing living costs, find themselves in need of extra financial assistance, and

Whereas, the available national loan programs have specific limitations, and

Whereas, present trends emphasize that private medicine at the county level continue to demonstrate a personal interest in these future practitioners of medicine, therefore be it

RESOLVED: All component county medical societies be urged to initiate or review active loan and scholarship programs for medical students residing in or coming from these respective counties.

THE REFERENCE COMMITTEE on Resolutions, H. F. Falls, M.D., Chairman, recommended approval of this Resolution after deleting, in the Resolved, the words "or review".

THE HOUSE adopted the report of the Reference Committee.

RESOLUTION 43

Michigan State University School of Human Medicine

Introduced by Robert M. Stow, M.D., Ingham

Whereas, the administration of Michigan State University and the Legislature of Michigan have had the foresight to establish the School of Human Medicine at Michigan State University, and

Whereas, there is a continuing need for qualified physicians in Michigan, therefore be it

RESOLVED: That this House of Delegates commend and offer its continuing support to Michigan State University and the Legislature of the State of Michigan in this worthwhile endeavor.

THE REFERENCE COMMITTEE on Legislation and Public Relations, D. N. Sweeny, M.D., Chairman, recommended approval of this Resolution and its transmittal, in proper form, to the Executive Office of Michigan State University and the Legislature of the State of Michigan.

THE HOUSE adopted the report of the Reference Committee.

SPECIAL MEMBERSHIPS

The Reference Committee on Special Memberships, R. M. Stow, M.D., Chairman, recommended approval of the following special memberships submitted by the component medical societies:

Life Memberships

Alpena County—E. S. Parmenter, M.D.

Berrien County—Hazel D. Eidson, M.D.; Clayton S. Emery, M.D.; Arthur A. McNabb, M.D.; Charles K. Stulik, M.D.; Richard W. Watkins, M.D.; Herbert O. Westervelt, M.D.

Genesee County—R. Gordon Brain, M.D.; J. Leonidas Leach, M.D.

Gratiot-Isabella-Clare—Dennis V. Smith, M.D.

Ingham County—Fanny H. Kenyon, M.D.

Jackson County—C. E. DeMay, M.D.; Ray Newton, M.D.; Theophile E. Schmidt, M.D.; James W. Townsend, M.D.; John D. Van Schoick, M.D.

Kalamazoo County—Irmel W. Brown, M.D.; Lolita G. Goodhue, M.D.; Donald C. Rockwell, M.D.; Cyril A. Youngs, M.D.

Kent County—Lawrence W. Faust, M.D.; John P. Marsh, M. D.; Elmer W. Schnoor, M.D.

Lenawee County—R. G. B. Marsh, M.D.

Marquette-Alger County—William A. Corcoran, M.D.

Oakland County—Ethan B. Cudney, M.D.; Laurie G. Rowley, M.D.

Saginaw County—Frederick J. Cady, M.D.; Oliver W. Lohr, M.D.; Frank O. Novy, M.D.; Frederick Pietz, M.D.; Clarence E. Tosach, M.D.

Sanilac County—Frances Adelia Ford, M. D.

Washtenaw County—Norman F. Miller, M.D.

Wayne County—Vinton A. Bacon, M.D.; Abraham Bloch, M.D.; Stanley H. Brown, M.D.; Clarence L. Candler, M.D.; Clarence J. Carpenter, M.D.; Joseph E. Ciprian, M.D.; Catherine Corbeille, M.D.; Wilfrid Cowan, M.D.; Robert L. Cowen, M.D.; Douglas Donald, M.D.; Elmond J. Gerondale, M.D.; William T. Greenlee, M.D.; William E. Hilton, M.D.; Louis H'Romadko, M.D.; William H. M. Johnson, M.D.; David Kallman, M.D.; Ralph F. Kernkamp, M.D.; William G. Mackersie, M.D.; Sophie Mishelevich, M.D.; Arthur H. Naylor, M.D.; Edgar E. Poos, M.D.; Edward L. Robb, M.D.; Joseph Rydezewski, M.D.; Carl H. Schulte, M.D.; William J. Scott, M.D.; George W. Sippola, M.D.; Leo W. Slazinski, M.D.; David I. Sugar, M.D.; Alfred H. Whittaker, M.D.; H. G. Yesayian, M.D.; George H. Zinn, M.D.

Retired Memberships

Bay-Arenac-Iosco County—Justis J. Austin, M.D.; Clyde S. Tarter, M.D.

Genesee County—Donald L. Bishop, M.D.

Ingham County—Walter E. Mercer, M.D.

Kalamazoo County—Paul G. Schrier, M.D.

Macomb County—Joseph M. Croman, Jr., M.D.

Muskegon County—Louis L. LeFevre, M.D.

North Central Counties—C. G. Clippert, M.D.

Oakland County—Malcolm D. Campbell, M.D.

Wayne County—Warren W. Babcock, M.D.; Raymond G. Colyer, M.D.; John Freedman, M.D.; John Louis Siefert, M.D.; L. Paul Sonda, M.D.

Wexford-Missaukee County—R. C. Norton, M. D.; Gordon C. Tornberg, M.D.

Honorary Memberships

Washtenaw County—Elizabeth C. Crosby, Ph.D.; Rueben L. Kahn, D.Sc.; Bradley M. Patton, Ph.D.

The list of candidates for Associate Membership from Oakland and Wayne Counties was reviewed. Since all candidates are doctors of medicine, no action was required by the House of Delegates, inasmuch as they may become Associate Members of this Society upon application and certification by the secretary of their component society.

THE HOUSE adopted the recommendations of the Reference Committee.

PRESENTATIONS AND AWARDS

PRESENTATION TO OUTGOING PRESIDENT ORLEN J. JOHNSON, M.D.

Speaker Lightbody presented a plaque to President Johnson: "Presented by the House of Delegates of the Michigan State Medical Society to Orlen J. Johnson, M.D., President 1963-1964. In deep appreciation and grateful recognition of distinguished service rendered to medicine."

CERTIFICATES OF COMMENDATION

President Johnson presented the following Certificates of Commendation as authorized by the House of Delegates:

John S. DeTar, M.D., Milan—

"In recognition of his contributions to medical and health organizations. An accomplished general practitioner, he first served his community. Then, with untiring zeal, he applied his widely-recognized talents as a writer, speaker and organizer to the successful advancement of the activities of state and national associations in medical and allied fields."

Robert M. Heavenrich, M.D., Saginaw—

"In recognition of his contributions in child health and welfare. A fine pediatrician, he has generously contributed his knowledge to regional and statewide child-serving agencies and organizations."

E. Gifford Upjohn, M.D., Kalamazoo—

"In recognition of his contributions in the medical profession and to community life as a doctor, an industrialist and a citizen. He especially merits commendation for his current service as Chairman of the Board of Directors of the Pharmaceutical Manufacturers Association."

Goldie B. Corneliuson, M.D., Lansing—

"In recognition of her contributions in maternal and child health programs in Michigan. Her leadership has resulted in cooperation which led to the Maternal Mortality Study and the Child Hearing Conservation Program."

Norman F. Miller, M.D., Ann Arbor—

"In recognition of his contributions in medical education and organizational work. A recognized authority in obstetrics and gynecology, he also has contributed mightily to cancer research."

Orus R. Yoder, M.D., Ypsilanti—

"In recognition of his contributions during a distinguished career in both public and private service to his city, county and state. As medical administrator of Michigan mental hospitals he has well served his profession and his fellow man."

FIFTY YEAR AWARDS

At the request of Speaker Lightbody, Secretary D. Bruce Wiley, M.D., presented the 50 Year Award to the following:

R. H. Baribeau, M.D., Calhoun County
C. D. Barrett, M.D., Monroe County
A. B. Bower, M.D., Macomb County
Audrey O. Brown, M.D., Wayne County
Malcolm D. Campbell, M.D., Wayne County
Harold E. Clark, M.D., Wayne County
Lyman W. Crossman, M.D., Wayne County
Ira G. Downer, M.D., Wayne County
Samuel J. Eder, M.D., Wayne County
David B. Hagerman, M.D., Kent County
Leslie T. Henderson, M.D., Wayne County
Arlington F. Lecklider, M.D., Wayne County
S. L. Loupee, M.D., Cass County
Reginald D. McGeough, M.D., Monroe County
Frank A. Mercer, M.D., Oakland County
John K. Ormond, M.D., Oakland County
Orlando W. Pickard, M.D., Wayne County
Arthur E. Schiller, M.D., Wayne County
Milton Shaw, M.D., Ingham County
Eugene Steinberger, M.D., Wayne County
Gerald A. Wilson, M.D., Wayne County

Doctor Wiley read the following names of 50 Year Awardees who were unable to be present:

Herbert C. Allison, M.D., Wayne County
Stilson R. Ashe, M.D., Wayne County
L. Byron Ashley, M.D., Wayne County
Carl C. Birkelo, M.D., Wayne County
Ladislaus Bogusz, M.D., Wayne County
Dudley W. Byers, M.D., Wayne County
George L. Caldwell, M.D., Wayne County
Aaron L. Chapman, M.D., Wayne County
Clarence M. Clark, M.D., Wayne County
Hazel Eidson, M.D., Berrien County
W. B. Fillinger, M.D., Clinton County
Herbert E. Fogt, M.D., Wayne County
R. John Hardstaff, M.D., Wayne County
A. B. Henderson, M.D., Wayne County
J. Stewart Hudson, M.D., Wayne County
Bror H. Larsson, M.D., Wayne County
Harry Lewin, M.D., Wayne County
F. L. Pierce, M.D., Cass County
Harry C. Saltzstein, M.D., Wayne County
Simon H. Sauter, M.D., Wayne County
J. G. Slaughenhaupt, M.D., Wayne County
Albert M. Wehenkel, M.D., Wayne County
David Weingarden, M.D., Wayne County
Carl G. Wencke, M.D., Calhoun County

EMPLOYEE AWARDS

President Johnson announced that by action of the House of Delegates in 1961 the employees of the headquarters staff of the Michigan State Medical Society were to receive awards for certain tenure of employment.

The following awards were presented by President Johnson:

Warren F. Tryloff—10 years' service.
Herbert A. Auer—5 years' service.

TRIBUTE TO DECEASED FORMER MEMBERS OF THE HOUSE OF DELEGATES

Secretary Wiley read the following names, and the members of the House arose and stood in silent tribute to their memory:

L. R. Keagle, M.D.	Calhoun
William H. Wacek, M.D.	Gogebic
Horace Wray Porter, M.D.	Jackson
William A. Scott, M.D.	Kalamazoo
Milton C. Smith, M.D.	Macomb
Glenn L. Coan, M.D.	Wayne
Charles J. Jentgen, M.D.	Wayne
George B. Hoops, M.D.	Wayne
J. Milton Robb, M.D.	Wayne
Francis P. Walsh, M.D.	Wayne

ELECTIONS

The following Councilors and Officers were elected:

President-Elect—Luther R. Leader, M.D., Birmingham

Speaker—James J. Lightbody, M.D., Detroit

Vice Speaker—Louis F. Hayes, M.D., Gaylord

Councilors (3-year terms)—

1st District: Edgar E. Martmer, M.D., Grosse Pointe; Don W. McLean, M.D., Detroit; Robert K. Whiteley, M.D., Detroit
4th District: Don Marshall, M.D., Kalamazoo
5th District: C. Allen Payne, M.D., Grand Rapids
6th District: Harold H. Hiscock, M.D., Flint
10th District: Edward H. Rodda, M.D., Bay City (to fill unexpired term to 1965)
14th District: Bradley M. Harris, M.D., Ypsilanti

Delegates to the American Medical Association
(January 1, 1965-December 31, 1966)
Sidney Adler, M.D., Detroit
George W. Slagle, M.D., Battle Creek
Donald N. Sweeny, Jr., M.D., Detroit

Alternate Delegates to the American Medical Association
(January 1, 1965-December 31, 1966)
(In order of seniority)
Ralph R. Cooper, M.D., Grosse Pointe
O. B. McGillicuddy, M.D., Lansing
Robert E. Rice, M.D., Greenville

Alternate Delegates to the American Medical Association
(To fill vacancies for terms expiring December 31, 1965)
W. C. C. Cole, Sr., M.D., Detroit (replacing Sidney Adler, M.D., elected Delegate)
Otto K. Engelke, M.D., Ann Arbor (replacing L. A. Drolett, M.D., resigned)

DIRECTORY

1964 MSMS House of Delegates

RECORD OF ATTENDANCE

	Meetings				
	1st	2nd	3rd	4th	5th
J. J. Lightbody, M.D., Speaker	X	X	X	X	X
Louis F. Hayes, M.D., Vice Speaker	X	X	X	X	X
D. Bruce Wiley, M.D., Secretary	X	X	X	X	X
C. I. Owen, M.D. Immediate Past President	—	—	—	—	—
DELEGATES					
ALLEGAN					
Lewis F. Brown, M.D.	X	X	X	X	X
ALPENA-ALCONA-PRESQUE ISLE					
John W. Bunting, M.D.	X	X	X	X	X
BARRY					
Robert J. Huebner, M.D.	X	X	X	X	X
BAY-ARENAC-IOSCO					
Wm. G. Gamble, Jr., M.D.	X	X	—	X	X
Robert C. Prophater, M.D.	X	X	X	X	X
BERRIEN					
Noel J. Hershey, M.D.	X	X	X	X	X
Paul O. Rague, M.D.	X	X	X	X	X
BRANCH					
Robert M. Leitch, M.D.	X	—	X	X	X
CALHOUN					
George T. Kelleher, M.D.	X	X	X	X	X
R. C. Rowan, M.D.	X	X	X	X	X
K. S. Wemmer, M.D.	X	X	X	X	X
CASS					
Sherman L. Loupee, M.D.	—	X	X	X	—
CHIPPEWA-MACKINAC					
Donald D. Finlayson, M.D.	X	X	X	X	X
CLINTON					
Franklin W. Smith, M.D.	X	X	X	X	X
DELTA					
Francis C. Anderson, M.D.	X	X	X	X	—
DICKINSON-IRON					
Donald T. Anderson, M.D.	X	X	X	X	X
EATON					
Byron P. Brown, M.D.	X	X	X	X	X
GENESEE					
Franklin W. Baske, M.D.	X	X	X	X	X
Lawrence G. Bateman, M.D.	X	X	X	X	X
Wm. F. Buchanan, M.D.	X	X	X	X	X
Clifford W. Colwell, M.D.	X	X	X	X	X
H. Maxwell Golden, M.D.	X	X	X	X	X
Phillip K. Stevens, M.D.	X	X	X	X	X
GOGEBIC					
John R. Franck, M.D.	X	X	X	X	X
GRAND TRAVERSE-LEELANAU-BENZIE					
Frank H. Power, M.D.	X	X	X	X	X
John R. Spencer, M.D.	X	X	X	X	X
GRATIOT-ISABELLA-CLARE					
John M. Wood, M.D.	—	X	X	X	X
HILLSDALE					
Luther W. Day, M.D.	X	X	X	X	X
HOUGHTON-BARAGA-KEWEENAW					
Andrew M. Roche, M.D.	Not represented				
HURON					
C. Willis Oakes, M.D.	X	X	X	X	X
INGHAM					
L. A. Drolett, M.D.	X	X	X	X	X
H. W. Harris, M.D.	X	X	X	X	X
D. Bonta Hiscoe, M.D.	X	X	X	X	X
Henry E. Malcolm, M.D.	X	X	X	X	X
R. M. Stow, M.D.	X	X	X	X	X
IONIA-MONTCALM					
Robert E. Rice, M.D.	X	X	X	X	X
JACKSON					
H. L. Oster, M.D.	X	X	X	X	X
John W. Rice, M.D.	X	X	X	X	—
KALAMAZOO					
W. Kaye Locklin, M.D.	X	X	X	X	X
Adrian J. Neerken, M.D.	X	X	X	X	X
Edwin O. Pearson, M.D.	X	X	X	X	X
Frederick C. Ryan, M.D.	X	X	X	X	X

	1st	2nd	3rd	4th	5th
KENT					
Noyes L. Avery, Jr., M.D.	X	X	X	X	X
W. Clarence Beets, M.D.	X	X	X	X	X
Fred C. Brace, M.D.	X	X	X	X	X
J. Russell Brink, M.D.	X	X	X	X	X
Leo J. Kenney, M.D.	X	X	X	X	X
John R. Pedden, M.D.	X	X	X	X	—
Allison R. VandenBerg, M.D.	X	X	X	X	X
Frederick S. Gillett, M.D.	X	X	X	X	X
LAPEER					
James R. Doty, M.D.	X	X	X	X	—
LENAWEE					
Donato F. Sarapo, M.D.	X	X	X	X	X
LIVINGSTON					
Edwin S. Woodworth, M.D.	X	X	X	X	X
LUCE					
B. G. Keizer, M.D.	—	—	—	X	—
MACOMB					
Maurice S. Reizen, M.D.	X	X	X	X	X
Peter V. Kane, M.D.	X	X	X	—	—
E. G. Siegfried, M.D.	—	X	X	X	X
MANISTEE					
Marlowe L. Schwarz, M.D.	X	X	X	X	X
MARQUETTE-ALGER					
George M. Wilson, Jr., M.D.	X	X	X	—	X
MASON					
Herbert G. Bacon, M.D.	X	X	X	X	X
MECOSTA-OSCEOLA-LAKE					
Paul Ivkovich, M.D.	X	X	X	X	X
MENOMINEE					
Herman R. Brukardt, M.D.	X	X	X	X	X
MIDLAND					
Harold L. Gordon, M.D.	X	X	X	X	X
MONROE					
S. Newton Kelso, Jr., M.D.	X	X	X	X	—
MUSKEGON					
Robert J. Fles, M.D.	X	X	X	X	X
H. Clay Tellman, M.D.	X	X	X	X	X
Leland E. Holly II, M.D.	—	—	X	X	—
NEWAYGO					
J. Paul Klein, M.D.	X	X	X	X	X
NORTH CENTRAL					
Charles L. Oppy, M.D.	X	X	X	X	—
NORTHERN MICHIGAN					
Thomas R. Kirk, M.D.	X	X	X	X	X
OAKLAND					
Carl H. Birkelo, M.D.	X	—	X	X	X
James E. Hendrickson, M.D.	—	X	—	—	—
Robert M. Bookmyer, M.D.	X	X	X	X	X
Arnold L. Brown, M.D.	X	X	X	X	X
Edward E. Elder, Jr., M.D.	X	X	X	X	X
Merle A. Haanes, M.D.	—	X	X	X	X
Paul T. Lahti, M.D.	—	X	X	X	X
James R. Quinn, M.D.	X	X	X	X	X
Vincent P. Russell, M.D.	X	X	X	X	X
F. Michael Sheridan, M.D.	X	X	X	X	X
Richard R. Galpin, M.D.	—	—	X	X	X
OCEANA					
Willis A. Hasty, M.D.	X	X	X	X	X
ONTONAGON					
James P. Strong, M.D.	X	X	X	X	X
OTTAWA					
John H. Kitchel, M.D.	X	X	X	X	X
SAGINAW					
Vernon V. Bass, M.D.	X	X	X	X	X
Hugh T. Caumartin, M.D.	X	X	X	X	X
Robert F. Powers, M.D.	—	X	X	X	X
ST. CLAIR					
James H. Tisdel, M.D.	X	X	X	X	X
ST. JOSEPH					
Stanley C. Penzotti, M.D.	X	X	X	X	X
SANILAC					
Keate T. McGunegle, M.D.	X	X	X	—	X
SHIAWASSEE					
Claude L. Weston, M.D.	X	X	X	X	X
TUSCOLA					
E. J. Miles, M.D.	X	X	X	X	—
VAN BUREN					
Edwin H. Terwillinger, M.D.	X	X	X	X	X
WASHTENAW					
Gerhard H. Bauer, M.D.	X	X	X	X	X
Harold F. Falls, M.D.	X	X	X	X	X
L. Dell Henry, M.D.	X	X	X	X	X
Howard R. Williams, M.D.	X	X	X	X	X
Beverly C. Payne, M.D.	X	X	X	X	X
Harry A. Towsley, M.D.	X	X	X	X	X
Charles J. Tupper, M.D.	X	X	X	X	X
Dean P. Carron, M.D.	X	X	X	X	X
Clarence E. Crook, M.D.	X	—	—	—	—
WAYNE					
Sidney Adler, M.D.	X	X	X	X	X
James J. Aiuto, M.D.	—	—	X	—	—
E. Clarkson Long, M.D.	—	X	X	X	X
Raphael Altman, M.D.	X	X	X	X	X
Raymond J. Barrett, M.D.	X	X	X	—	—
Eldon C. Baumgarten, M.D.	X	—	—	X	—
Alexander Blain, III, M.D.	X	X	X	—	X
James B. Blodgett, M.D.	X	X	X	X	X
Z. Stephen Bohn, M.D.	X	X	X	X	X
George T. Bradley, M.D.	X	—	—	—	—
Wm. L. Brosius, M.D.	X	X	X	X	X
Brock E. Brush, M.D.	X	—	X	X	X
Wyman C. C. Cole, Jr., M.D.	X	X	X	X	X
Ralph R. Cooper, M.D.	X	X	X	X	X
James C. Danforth, M.D.	X	X	X	X	X
Charles E. Darling, M.D.	X	X	X	X	X
A. Jackson Day, M.D.	X	X	X	X	X
Melvin S. Dennis, M.D.	X	X	X	X	X
Herbert W. Devine, M.D.	X	X	X	X	X
Henry M. Domzalski, M.D.	X	X	X	X	X
Russell F. Fenton, M.D.	X	X	X	X	—
George S. Fisher, M.D.	X	X	X	X	X
James D. Fryfogle, M.D.	—	X	X	X	X
Carl A. Gagliardi, M.D.	X	X	—	X	—
Louis E. Heideman, M.D.	X	X	X	X	X
Joseph Hickey, M.D.	X	X	X	X	X
Homer A. Howes, M.D.	X	X	X	X	X
Benjamin Jeffries, M.D.	X	X	X	X	X
Lyle W. Korum, M.D.	X	—	—	—	X
Luther R. Leader, M.D.	X	X	X	—	X
Floyd B. Levagood, M.D.	X	X	X	X	X
Arthur B. Levant, M.D.	X	X	X	X	X
Max L. Lichter, M.D.	—	X	X	—	X
James J. Lightbody, M.D.	X	X	X	X	X
Rosser L. Mainwaring, M.D.	X	—	X	—	X
Marjorie Peeples Meyers, M.D.	X	X	X	X	X
G. Thomas McKean, M.D.	X	X	X	X	X
John W. Moses, M.D.	X	X	X	X	X
Frank S. Perkin, M.D.	X	X	X	X	X
Mario A. Petrini, M.D.	X	X	—	X	—
Ralph H. Pino, M.D.	X	X	X	X	X

	1st	2nd	3rd	4th	5th
A. Hazen Price, M.D.	X	X	X	X	X
Howard C. Rees, M.D.	X	X	X	X	X
George L. Reno, M.D.	X	X	X	X	X
Francis P. Rhoades, M.D.	X	X	X	X	X
A. Zack Rogers, M.D.	X	X	X	X	X
Jack Rom, M.D.	X	X	X	X	X
Laurence F. Segar, M.D.	X	—	X	X	X
Reuben I. Shapiro, M.D.	X	—	X	—	X
John G. Slevin, M.D.	X	X	X	X	X
David I. Sugar, M.D.	X	X	X	—	—
Robert G. Swanson, M.D.	X	X	X	X	X
Donald N. Sweeny, M.D.	X	X	X	X	X
Milton R. Weed, M.D.	X	X	X	X	X
Wm. J. Yott, M.D.	X	X	X	X	X
Raymond J. Kokowicz, M.D.	X	X	X	X	X
WEXFORD-MISSAUKEE					
Gregory P. Moore, M.D.	X	X	X	X	X

	1st	2nd	3rd	4th	5th
MEDICAL STUDENTS					
University of Michigan					
John Beernink	X	X	X	X	X
Terry Chamberlain	X	—	X	—	X
Harvey Chapin	X	X	X	X	X
Arthur Fleming	X	X	X	X	X
Charles Henry	X	X	X	X	X
John Markly	X	X	X	—	—
Wayne State University					
Charles Jackson	X	—	—	X	—
James Meeks	X	—	X	X	X
Wm. C. Munn	X	X	X	X	X
James Reese	X	—	X	X	—
Henry Taylor	X	X	X	X	X
Martin Zonca	X	X	X	X	X

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C. Allen Payne, M.D., Grand Rapids

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